



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	<p>Full - CCKY has implemented a QAPI program as outlined in the QI Program Description, QI Work Plan and UM Program Description. These include: program goals and objectives, EQIC Description, components of improvement activities, governing body and committee structures/roles, available resources, and process of program evaluation.</p> <p>The 2012 Annual Evaluation provides a comprehensive report on the plan's approach to ensuring quality of care. EQIC committee and reporting subcommittees meet quarterly. Minute summaries (report 21) and PIP reports reveal that assessment; monitoring, evaluation and improvement processes are ongoing.</p> <p>On interview, CCKY described its 2013 goals as:</p> <ul style="list-style-type: none"> ▪ Improving access and availability ▪ Decreasing inappropriate ED utilization ▪ Increasing the number of women who complete postpartum visits ▪ Improving care for major depression and ADHD (PIPs) ▪ Decreasing post op infection rates ▪ Addressing substance abuse in pregnancy ▪ Improving continuity of care/decreasing preventable inpatient readmissions (PIP) ▪ Increasing rates of EPSDT services ▪ Developing disease management programs for prevalent chronic diseases. 	Full	<p>Includes review of MCO Report #84 QAPI Program Description</p> <p>Addressed in the 2014 QI Program Description: Summary, Policies and Procedures, QI Work Plan, and QI Committee Structure.</p> <p>The 2014 QI Program Description Summary describes the program goals and objectives, the national and local MCO- level program structure, the governance (Board of Directors (BOD), CEO and Executive Quality Improvement Committee (EQIC)), corporate and regional resources, behavioral health (BH) QI, the QI Work Plan, QI Evaluation, and the role of the EQRO.</p> <p>Coventry indicated that in 2014 and 2015, the QI Program has been transitioning to the Aetna structure.</p> <p>Changes in 2015 include: Increasing QM/UM Committee meeting frequency from quarterly to monthly.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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			<p>Transitioning oversight of the program from the EQIC to the Quality Management Oversight Committee (QMOC) Meetings will increase from quarterly to bi-monthly</p> <p>Adding an Appeals and Grievances Committee as a sub-committee of the Compliance Committee.</p> <p>Transitioning Delegation Oversight from the Provider Network Department to the Compliance Department.</p> <p>Monitoring of quality of care for re-credentialing via the Aetna quality of care database.</p> <p>Changing meeting frequency of the Peer Review Committee to as needed.</p> <p>Implementation of the QI Program is demonstrated in the 2014 QI Work Plan quarterly updates and related documents (e.g., PIPs, meeting minutes), and in the 2013 QI Evaluation.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
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			<p><u>Recommendation for Coventry</u> Coventry should consider adding a list of the specific QI activities that are conducted in order to fulfill the program goals and objectives to its QI Program Description.</p>	
<p>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.</p>	<p>Full - CCKY Kentucky's 2013 UM Program Description and QI Program Description describe the structure and processes that CCKY has implemented to monitor, evaluate and improve care and services.</p> <p>The UM Program Description identifies the roles of staff and the committee structure in place to support quality initiatives.</p> <p>The overview of the EQIC committee and QMUM subcommittee includes monitoring and oversight of key indicators such as adverse events, HEDIS measures, and adoption of clinical guidelines.</p> <p>The 2012 Annual Evaluation and the 2013 QI Program Description provide detailed descriptions of the methods used to monitor, evaluate and improve care and services.</p> <p>The QI Program Description identifies the roles of staff and the committee structure in place to support quality initiatives.</p> <p>Results of activities including conducting population analysis,</p>	<p>Full</p>	<p>Addressed in the 2014 QI Program Description, Goals on page 3; Objectives on pages 4-6; Corporate and Regional Resources and key performance indicators on pages 14-15.</p> <p>The 2014 QI Work Plan and quarterly updates outline the program activities.</p> <p>The EPSDT activities are incorporated into the QI Work Plan and addressed in the separate HEDIS/EPSDT/ Performance Measure Work Plan.</p> <p>The 2013 QI Evaluation describes the outcomes and results of the program activities.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p>improving access to care, assuring continuity of care, evaluating and disseminating clinical guidelines, monitoring grievances and appeals. Conduct of performance improvement projects is described in the 2012 Annual Evaluation.</p> <p>The Work Plan indicates that CCKY conducts annual reviews of the assessment, analysis and implementation of interventions for member and provider grievances and appeals, cultural factors that impact members, behavioral health issues, utilization and clinical data, access and availability and network adequacy. Also, the Work Plan outlines specific processes underway for evaluating health care outcomes, including HEDIS measures.</p> <p>According to the 2012 Annual Evaluation, delegation oversight processes are in place to monitor and evaluate subcontractors. Monthly meetings cover operational concerns. Quarterly oversight meetings are held to review performance, delivery of services, and relevant updates to policies and procedures. All delegates undergo a formal review annually.</p> <p>P/P PR-006 describes the processes for evaluating appointment availability. CCKY monitors the availability of appointments using a secret shopper methodology. Per P/P PR-006, a percentage of PCPs are surveyed annually using secret shopper calls to assess appointment availability for urgent care, routine care, preventive care and specialty care.</p> <p>The Utilization Management Program Description describes processes to monitor and report a variety of quality measures</p>			



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p>including medical necessity, timely care, consistency in authorization of care, care based on clinical standards, and appropriate cost of care.</p> <p>The Work Plan reflects tracking of adverse events and member and provider complaints and grievances (category, type intervention and turnaround times).</p> <p>Health Risk Assessment (HRA) completion rates are monitored by the plan.</p> <p>The Annual Evaluation describes several processes to improve care provided to members with results. CCKY conducted two PIPs, developed care management programs for members with chronic and/or behavioral health conditions, implemented interventions to improve rates of postpartum care compliance, and to ensure PCP follow-up after inpatient discharge.</p> <p>CCKY conducted its first CAHPS survey (report 94) to assess member satisfaction. The results revealed opportunities to improve shared decision making, communication between member and providers, overall rating for adult care, overall rating for the plan, and customer service. The plan's provider newsletter provided information on how to improve shared decision making. This topic was also covered in the Quality Member Access Committee (QMAC) meeting minutes.</p> <p>In 2013, IPRO recommended that CCKY should ensure appropriate identification and categorization of all member</p>			



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p>quality of care concerns, investigate trends in quality of care concerns and adverse events when there are sufficient data to analyze by type (e.g., hospital acquired infections).</p> <p>The grievance file review reflected a substantial improvement in referrals for potential quality of care concerns (see Grievances tool for details).</p> <p>CCKY conducted a focused study on post-op wound infections. The study revealed that the infections were primarily due to member non-compliance. CCKY initiated a discharge planning program and home health follow-up to address the finding.</p> <p>The prior review revealed that CCKY staff was concerned about after-hours access and provider availability in rural areas and was also monitoring and evaluating ED utilization and Geo Access reports. In response, CCKY has worked with hospitals to develop urgent care services and recruiting additional urgent care centers: Kroger, CVS Minute Clinic, and some Wal-Mart stores. CCKY is conducting a PIP focused on reducing unnecessary ED utilization.</p> <p>In the prior review, it was noted that although the quarterly reports indicate that CCKY monitors EPSDT screening rates this was not included in the QI Work Plan. On interview, CCKY stated that there is a dedicated work plan for EPSDT initiatives. The EPSDT work plan was reviewed and includes monitoring and follow-up of EPSDT screening rates.</p>			



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p><u>Recommendation for CCKY</u> CCKY should consider referencing the EPSDT work plan in the QI Work Plan or include as an attachment to the QI Work Plan.</p>			
<p>The Contractor's QI structures and processes shall be planned, systematic and clearly defined.</p>	<p>Full - The plan has implemented a QAPI program as outlined in the QI Program Description, the UM Program Description, and 2012 Annual Evaluation as described above. The stated purpose of the QAPI program is to monitor and improve outcomes of care, services, safety, and satisfaction and to promote culturally competent, cost effective delivery of services. The QI Work Plan outlines planned QI activities.</p> <p>In 2013, IPRO recommended that CCKY consider describing the status and activities completed in the QI Work Plan.</p> <p>The QI Work Plan has been updated to include a comments column where descriptive updates are provided. Additionally, the committee meeting minutes provide detailed information.</p>	Full	<p>Addressed in the 2014 QI Program Description (entire document), and the 2014 QI Work Plan.</p> <p>Evidenced in the 2014 QI Work Plan quarterly updates and related documents (PIPs, meeting minutes, reports) and in the QI Evaluation.</p>	
<p>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.</p>	<p>Full - Preparations for NCQA accreditation survey are in process. This is reflected in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan. The on-site review will take place on 07/28/14 and 07/29/14 with a look-back period of 6 months (new plan).</p> <p>CCKY provided the HEDIS measure results. The QMUM meeting minutes discuss how lower performing measures will be addressed. A Provider newsletter (Vol 1 Issue 2) describes HEDIS improvement initiatives focusing on preventive health services/ screenings and chronic disease management. Documentation</p>	Full	<p>Addressed in the 2014 QI Program Description, Goals on page 3; Objectives on pages 4-6; 2014 QI Work Plan on page 16; and QI Evaluation on page 17.</p> <p>External Quality Review activities are described on page 17 of the 2014 QI Program Description.</p> <p>Linkage is demonstrated in the 2014 QI</p>	



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Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>revealed that CCKY intends to target the following measures for improvement: lead screening (LSC), weight assessment and counseling (WCC), well care visits (15 months, 3 – 6 years), prenatal and postpartum care (PPC) and a variety of chronic care measures (e.g., CDC, CBP, among others).</p> <p>The QI Program Description outlines the process for linking evaluation data from various sources to QI initiatives.</p> <p>The Work Plan includes the rationale for activity selection, which include accreditation, contract requirements, EQRO review, or delegation oversight.</p> <p>The 2012 Annual Evaluation identifies hospital acquired infections (HAI) as the most commonly occurring adverse event. HAIs are tracked and reports are reviewed monthly by Medical Director and QMUM reviews these events bi-annually. Corrective action is implemented.</p> <p>Quality of care issues per policy are tracked, analyzed and referred to appropriate committees (QM/UM, Peer Review), and meeting minutes include discussion of potential quality concerns.</p> <p>2014 PIP proposal focuses on reducing hospital readmissions. 2013 PIPs focus on identification and treatment of major depression and reduction of ED utilization. All PIP indicators demonstrate substantial opportunity for improvement.</p> <p>2013 was the first year that CCKY administered the CAHPS</p>		<p>Work Plan and updates and in the 2013 QI Evaluation.</p> <p>In 2014, IPRO suggested that Coventry include HEDIS Adolescent Well Care (AWC) and Frequency of Ongoing Prenatal Care (FOP) among the measures targeted for improvement since a large proportion of the membership is < age 21 or women of child-bearing age and the HEDIS 2013 rates presented an opportunity for improvement.</p> <p>The MCO addressed this through measuring and improving HEDIS and Healthy Kentuckians (HK) Performance Measures related to adolescents and pregnant women as evidenced in the 2014 HEDIS/Healthy Kentuckians/ EPSDT Work Plan.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>survey. The CAHPS survey report (report 94) identified the following as opportunities for improvement: shared decision making, overall rating for adult care, overall rating for plan, and provider communication with members. An internal workgroup discussed barriers and interventions were developed.</p> <p>The provider satisfaction survey had a 24% response rate and revealed the following opportunities for improvement: resolution of inquiries, claims/payment process, and prior authorizations process. Interventions were not discussed.</p> <p>Recommendation for CCKY It was suggested that CCKY consider including HEDIS adolescent well care (AWC) and frequency of prenatal care (FOP) among the measures targeted for improvement since the majority of the MCO's membership is children and women of child-bearing age.</p>			
<p>The QAPI program shall be developed in collaboration with input from Members.</p>	<p>Full - 2013 was the first year that CCKY administered the CAHPS survey. The CAHPS survey report (report 94) identified the following opportunities for improvement: shared decision making, overall rating for adult care, overall rating for health plan, and provider communication with members. An internal workgroup discussed barriers and interventions were developed.</p> <p>The QI Program Description and CCKY quarterly reports identify the Quality and Member Access Committee (QMAC) as a subcommittee of the Executive QI Committee. The purpose of the committee is to obtain feedback from members on marketing materials, customer service, network access, benefit</p>	<p>Minimal</p>	<p>The 2014 QI Program Description only briefly mentions the Quality and Member Access Committee (QMAC) under the sub-heading Ad Hoc sub-Workgroups and sub- Committees on page 14.</p> <p>The membership, roles, and responsibilities of the committee are not described.</p> <p>QMAC meeting minutes were</p>	<p>QMAC meeting formats and agendas have been updated to include review and opportunity for feedback and input related to QI program documents and ongoing QI activities. This will be documented in the minutes.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p>interpretation, and the health plan overall. The meetings occur quarterly by region. Meeting minutes reflect conduct of the stated activities and input from members on the QAPI program. Discussions included an overview of QI Program Description and Work Plan, HEDIS measures, NCQA process, CAHPS survey, and review of the Member Handbook, Provider Directory, and formulary. Members expressed concerns over barriers to access to dental care. These concerns were brought to the EQIC committee as documented in EQIC meeting minutes.</p> <p>Upon interview, CCKY described the actions taken to evaluate and address the member concerns regarding dental access. Avesis, the dental vendor, conducted a GeoAccess evaluation which revealed that access was adequate and that member perception may be the root of the complaints. Avesis also undertook an initiative to link members to network orthodontists.</p>		<p>provided. The minutes did not demonstrate that the 2014 QI Program Description, 2014 QI Work Plan, or 2013 QI Evaluation were provided or reviewed by the committee.</p> <p>Coventry did describe the QI activities (e.g., HEDIS) to the committee; however, no committee input was documented.</p> <p>It appears that the committee was less structured and less active than in the prior year.</p> <p><u>Recommendation for Coventry</u> Coventry should ensure that the QMAC is provided with the QI program documents for review and input and that the committee routinely has input into the ongoing QI activities. This should be documented in the minutes.</p>	
<p>The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.</p>	<p>Full - QMAC minutes described the activities and discussion of the committee as stated previously. In addition to the member concerns about access to dental care, issues with medical appointment availability and availability of interpreters were expressed. CCKY staff at the QMAC meetings encouraged</p>	<p>Minimal</p>	<p>The QMAC meeting held on 3/9/2014 documented the greatest level of input from the committee members.</p> <p>Most often, the meeting content</p>	<p>QMAC meeting formats and agendas have been updated to include review and opportunity for feedback and input related to QI program documents and ongoing QI activities. This will be</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p>members to file grievances and use the 24 hour Nurse line when needed. Members can access a copy of the QI Program Strategy through Customer Service and on the website.</p> <p>During the onsite review, CCKY described efforts to expand its provider network and monitoring of access to care in each region. CCKY also explained that the MCO uses a language line type service and has interpreters available to attend inpatient visits and assist members in the hospital. CCKY described an issue related to translation of Burmese, but it was a knowledge issue and was addressed. Members' primary language other than English is Spanish. The call center located in Houston is staffed with English/Spanish bilingual associates.</p>		<p>consisted of MCO staff providing information on Coventry programs and activities. This was useful information for the committee members, but did not directly afford the opportunity for input into the QI Program activities or for the QMAC to fulfill its required functions.</p> <p><u>Recommendation for Coventry</u> As noted above, Coventry should ensure that the QMAC is provided with the QI program documents for review and input and that the committee routinely has input into the ongoing QI activities. This should be documented in the minutes.</p>	<p>documented in the minutes.</p>
<p>The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.</p>	<p>NA - CCKY is preparing for its initial NCQA accreditation survey and this is reflected in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan. Preparations have included mock audits. The accreditation survey is scheduled for 07/28/14 and 07/29/14. MHNNet, the BH vendor, hold both URAC and NCQA accreditation.</p>	<p>Full</p>	<p>Coventry achieved NCQA-accreditation with Accredited status for the period 8/21/2014-8/21/2017.</p>	
<p>The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report</p>		<p>Minimal</p>	<p>Accreditation documents provided for the onsite review included only the NCQA cover letter and accreditation certificate.</p>	<p>Coventry explained during the EQRO audit of communication errors when delivering the result of the NCQA audit via email to DMS. Email trail was</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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<p>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.</p>			<p>During the onsite review, Coventry provided a copy of an email regarding the accreditation documentation that was sent to DMS; however, the specific report components/attachments included were not discernible.</p> <p>DMS has a record of receiving only the accreditation certificate.</p> <p>Coventry needs to provide the following reports from the NCQA Interactive Survey System (ISS) to DMS with each accreditation cycle: A copy of the complete survey report that includes: The scoring at the category, Standard, and element levels Status Summarized & Detailed Results Performance Performance Measures Must Pass Results NCQA Recommendations History.</p> <p><u>Recommendation for Coventry</u> Coventry should provide the</p>	<p>provided that showed difficulties on DMS side in opening the documents. DMS was finally able to open the certificate. The final report was submitted to DMS and EQRO prior to the EQRO on site audit being concluded.</p> <p>HEDIS and CAHPS review was not included in this NCQA audit.</p> <p>Coventry will provide the documentation listed for each accreditation survey and any interim updates.</p> <p>At the next accreditation review in 2017, Coventry will include both standards and HEDIS/CAHPS performance review.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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			<p>documentation listed above to DMS as soon as possible and thereafter, for each accreditation survey and any interim updates.</p> <p>Final Review Determination No change in review determination.</p> <p>DMS confirmed that the accreditation report was not received in the review year, CY 2014. It was received in 3/2015, during the onsite review.</p> <p>The MCO needs to provide the accreditation documentation, as required by the contract, when the accreditation results are received. A copy of the complete survey report with all applicable elements.</p> <p>Upon the next review, IPRO will review the accreditation documentation submitted to DMS to ensure same.</p>	
Annually, the Contractor shall submit the QAPI program description document to the Department for review.	Full - Work Plan indicates the QI Program Description was submitted in July 2013. May 22, 2013 EQIC meeting minutes indicate that the description was sent to DMS by the time of the EQIC meeting.	Full	The 2014 QI Program Description was submitted in July 2014.	
The Contractor shall integrate Behavioral	Full - MHNet, an NCQA accredited Managed Behavioral Health	Substantial	MHNet administers and manages BH	Coventry is actively seeking and



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Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

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<p>Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.</p>	<p>Care Organization (MBHO) and CCKY subsidiary administers and manages behavioral health services (mental health and substance abuse). The QI Program Description indicates that behavioral health and physical health services are coordinated to improve identification of and care for members with behavioral health needs at both the plan and individual member level.</p> <p>Behavioral health services are integrated into the QAPI program. Behavioral health QI and UM activities are delegated to MHNet, but behavioral health and physical health staffs actively collaborate on PIPs and other initiatives (e.g. substance abuse among pregnant women and behavioral health-physical health continuity of care). CCKY and MHNet hold regular operational meetings to monitor performance.</p> <p>Behavioral health has representation on the Executive Quality Improvement Committee (EQIC) and Quality Management/Utilization Management (QM/UM) Committee. EQIC and QM/UM meeting minutes demonstrate discussion of behavioral health issues, such as adoption of behavioral health clinical guidelines.</p> <p>MHNet behavioral health care advocates are co-located at the health plan to integrate treatment and case management activity, and to coordinate with physical health case managers. The collocation also facilitates referrals between behavioral health and physical health. The 2012 Annual QI Evaluation indicates that there is common coordination of care screening and referral form for formal requests. This was seen in the PH/BH file review.</p>		<p>services, including mental health and substance abuse treatment services.</p> <p>Addressed in the 2014 QI Program Description on page 16. The 2014 QI Work Plan references ensuring BH Access; review/approval of BH Clinical Practice Guidelines (CPGs); availability of BH services; and continuity and coordination of physical health (PH) and BH.</p> <p>The 2014 QI Program Description, Committee Structure, on page 10, indicates that a BH practitioner or doctorate-level BH practitioner serves as a member of the QM/UM Committee.</p> <p>Review of the committee meeting minutes revealed that several MHNet and Aetna BH staff persons are members, but a network BH practitioner is not listed among the members.</p> <p>Similarly, in the 2014 QI Program Description, Behavioral Health, on page 16, the description reads that a</p>	<p>recruiting BH practitioners to participate in the quality committees.</p> <p>BH has been integrated in to health services. A full time BH practitioner has been staffed in the Health services department and participates in the quality committees. This practitioner is working with quality committees to recruit external practitioners for participation.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

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	<p>The QI Program Strategy indicates that members are surveyed regarding behavioral health needs across the existing quality programs.</p> <p>The 2012 Annual Evaluation describes weekly CCKY/MHNet team meetings and case management rounds offer additional opportunity for CCKY and MHNet staffs to interact.</p> <p>Finally, CCKY monitors behavioral health utilization indicators and there is MHNet input for the 2013 and 2014 PIPs.</p>		<p>BH practitioner serves as a member of the EQIC, but the agendas and minutes do not reflect this.</p> <p>Demonstrated in the 20014 HEDIS/HK/EPSTDT Work Plan, which includes the MCO's activities related to HEDIS Antidepressant Medication Management (AMM); in the PIPs related to major depressive disorder (MDD), ADHD, and the State-collaborative PIP on use of antipsychotics for children and adolescents; and in Report #17 QI Work Plan quarterly updates.</p> <p>Integration of BH and PH care were discussed at the QM/UM meetings held on 2/20/2014 and 6/19/2014. At the April meeting, the committee reviewed the MHNet Annual Evaluation.</p> <p>The 2013 QI Evaluation notes that a workgroup, consisting of Coventry and MHNet staff members was established in 2012.</p> <p>The group implemented interventions</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>for the MDD PIP. Assessment of BH quality was limited to information in the 2013 QI Evaluation since the MHNNet Annual Evaluation was not provided.</p> <p><u>Recommendation for Coventry</u> Coventry should ensure that the BH practitioners listed in the committee descriptions are recruited to participate in the quality committees.</p>	
<p>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.</p>	<p>Full - The QI Program Description reveals that behavioral health (BH) QI program is integrated into the plan's QI program. MHNNet provides regular representation in QI committees and workgroups. The plan monitors BH services through annual oversight audits.</p> <p>Major Depression PIP described BH and PH grand rounds meet weekly to assess high-risk patients with both behavioral and medical concerns in order to develop a plan of care. There is also a joint tracking tool used by plan case managers and MHNNet. The resulting care coordination may have contributed to demonstrated improvement during the interim measurement.</p> <p>MHNNet is also involved in the ED utilization PIP through joint case management services care coordination and development of case management tool.</p> <p>As per the 2012 Annual Evaluation, MHNNet and CCKY case</p>	<p>Full</p>	<p>Addressed in the 2014 QI Program Description, Goals on page 3 and Behavioral Health on page 16.</p> <p>The BH QI program is integrated into the MCO's QI program. Several MHNNet staff persons are members of the EQIC and QM/UM committees and workgroups.</p> <p>Monitoring of BH services and PH outcomes is demonstrated in annual oversight audits; HEDIS reporting; review of the MHNNet Annual Evaluation; and conducting PIPs and other quality initiatives related to BH conditions, which are documented in the committee meeting minutes.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>managers meet together for case rounds for those members requiring BH and PH services. The BH and PH case managers also refer members as needed for PH and/or BH issues. Completed referral forms were seen in the BH/PH Coordination file review.</p> <p>QMUM meeting minutes reflect joint reporting from case managers and MHNet. QMUM also reviews BH collaborations such as prevention program focused on ADHD, Anxiety, Depression in the Older Adult, and post partum depression.</p>		<p>Assessment of BH quality was limited to information in the 2013 QI Evaluation since the MHNet Annual Evaluation was not provided.</p>	
19.2 Annual QAPI Review				
<p>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</p>	<p>Full - The 2012 Annual Evaluation reviews activities for the period between Jan 1, 2012 to December 31, 2012. The evaluation provides an in depth overview of the QAPI program. It includes a population analysis, which reveals that the plan covers about 24% of the entire KY Medicaid population. Children ages 18 years and under represent 64% of the membership.</p> <p>Linguistics analysis showed 3,000 Spanish-speaking members in their database. The plan, in turn, developed Spanish tag lines on all member mailings and translated mailers to each identified Spanish –speaking member. Translation services are offered through the toll free phone number as described in the Member Handbook. Language assistance services, TDD services, and person-to-person interpretation services are also available.</p> <p>High volume episode reporting is reported as a way to identify clinical priorities. The top 25 diagnoses included ADHD, COPD, acute URI, asthma, low back pain, diabetes and hypertension.</p>	<p>Substantial</p>	<p>Includes review of MCO Report #85 QI Plan & Evaluation</p> <p>The 2013 QI Evaluation contains a review of activities for the period January 1, 2013 to December 31, 2013 and was submitted to DMS as required.</p> <p>Key findings included: The top 2 diagnoses (by volume) for female members are supervision of other than normal pregnancy and routine infant or child check.</p> <p>The top 2 diagnoses (by volume) for male members are routine infant or child check and ADHD.</p>	<p>Coventry will assess improvement/deficiencies between the 2013 and 2014 annual eval and focus HEDIS, EPSDT, Prevention and Wellness, QMAC, provider access and satisfaction efforts towards opportunities for improvement.</p> <p>Areas of concern to focus on: Well care visits for all age groups: 15 months, ages 3-6 years and adolescents.</p> <p>Preventive services for children and adolescents: immunizations and lead screening; documentation of immunizations in the medical record; risk screening for adolescents; and</p>



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.</p>	<p>The plan compared the high volume diagnoses with those of the high volume ED visits and found commonalities that will be addressed in the 2013 PIP – ED Utilization. The Disease Management programs focus on 6 diseases: asthma, diabetes, coronary artery disease, chronic kidney disease, heart failure, and COPD. An ADHD focused PIP was designed in collaboration with MHNNet.</p> <p>Access to Care was analyzed. This included a review of customer service, language line access, 24 hour nurse line use, appointment wait times, and network/geographic availability. As a result, CCKY conducted additional staff training, evaluated of McKesson (nurse line vendor) performance, improved the disease management program, changed the vendor used for the secret shopper Access/Availability (A/A) survey, and recruited additional providers in rural regions.</p> <p>Member satisfaction was assessed using the CAHPS survey. Results were not available at the time that CCKY prepared the 2012 QI program evaluation report. Grievances were analyzed. The top categories were: customer service, quality of care, and quality of service. CCKY planned to address these issues with additional training and education, a new electronic Grievance/Appeal (G/A) filing system, and a new Quality Check program for grievance processing.</p> <p>Evaluation of Clinical Care included a review of UM telephone access and CCKY met the metrics. To maintain the performance, CCKY developed a monitoring program to evaluate the</p>		<p>All Customer Service metrics met goal except overall call quality (96.40% versus 98%) and Claims Paid within 30 Days (98.60% versus 99%)</p> <p>All Pharmacy Call metrics met or exceeded requirements.</p> <p>The NurseLine diverted 87% of callers seeking ED care.</p> <p>Appointment availability for OB 3rd trimester visits is in need of improvement.</p> <p>36% of after-hours calls were not answered per requirements.</p> <p>GeoAccess standards were met for PCPs and specialists.</p> <p>CAHPS member satisfaction for Shared Decision-Making was below the national average for adult, child and CHIP members.</p> <p>CAHPS Rating of Health Plan was below the national average for adult</p>	<p>measurement and documentation of BMI/percentile and counseling for nutrition and physical activity.</p> <p>Prenatal risk screening and counseling; availability of 3rd trimester visits; and postpartum visits and screening for postpartum depression.</p> <p>Care for members with diabetes.</p> <p>Cervical cancer and Chlamydia screening.</p> <p>After-hours telephone access.</p> <p>Overall provider satisfaction.</p> <p>Member satisfaction with shared decision-making and the health plan overall.</p> <p>Coventry will assess the availability of member materials in Spanish and increase availability if deficiencies are noted.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>representatives' accuracy, courtesy and responsiveness. CCKY noted a decrease in authorization requests which was attributed to refining the prior authorization list and educating providers.</p> <p>An analysis of bed days prompted CCKY to promote timely discharge and enhance the High Risk OB and Case Management programs.</p> <p>UM denials were reviewed. This revealed the need to direct members to in-network providers.</p> <p>Inter-rater reliability testing of UM reviewers was found to be very good and was followed by reinforcing the application and interpretation of UM criteria.</p> <p>CCKY planned to use monthly HEDIS measure performance reports to inform ongoing interventions. For services not assessed by HEDIS, the Kentucky-specific measures were to be used. CCKY planned to initiate provider feedback regarding HEDIS performance and non-compliance with guidelines through the provider targeted website – directprovider.com.</p> <p>Two PIPs were in process during 2012. The topics were priority areas for the state, Antidepressant Medication Management and Compliance, and Decreasing Non-emergent/ Inappropriate ED Utilization. CCKY formed multidisciplinary workgroups to design and monitor the PIP interventions. These workgroups included representatives of MHNNet (BH vendor). The PIP results were not available at the time of the 2012 CCKY QI program evaluation</p>		<p>and CHIP members.</p> <p>Appeal timeliness was between 92 – 100% and < 25% of decisions were overturned.</p> <p>Grievance turn-around time was consistently < 30 days. Some issues with improper routing were identified and corrected.</p> <p>Clinical guidelines were updated and incorporated into the CCM and DM programs</p> <p>Coventry reported HEDIS and HK Performance Measures for the first time in 2013.</p> <p>The following HEDIS measures benchmarked at or above the 75th percentile: ADV, AMM, CAP 12-24 months, CAP 25 months – 6 years, and PPC –Timeliness of Prenatal Care.</p> <p>The following HEDIS measures benchmarked at or below the 25th percentile: Adolescent Well Care, Cervical Cancer Screening, Childhood</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>report.</p> <p>Due to the first HEDIS and performance measure reporting to occur in 2013, there was no Pay-for-Performance program.</p> <p>In 2012, CCKY identified over 31,000 members for their disease management programs. The effectiveness and satisfaction of the disease management programs will be evaluated in 2013.</p> <p>Medical record audit prompted CCKY to educate and encourage providers to promote advanced directives and practice BMI assessment and documentation. Follow-up audits are scheduled in 2013.</p> <p>The 2012 Annual Evaluation describes delegation oversight findings and corrective action as necessary. The plan engages vendors for behavioral health, chiropractic, dental, pharmacy, 24 hour nurse line, and pain management services. They also use vendors for external review, and radiology utilization management services.</p> <p>Quality of care issues and adverse events are monitored monthly. The highest rate was seen in the second quarter. This may have been the result of CCKY implementing a new reporting system. Hospitals had the highest number of quality referrals due to surgical site infections.</p> <p>CCKY documented several activities to ensure continuity and coordination of care. MHNNet is highly integrated in activities that</p>		<p>Immunization Status – Combo 2, Chlamydia Screening, Comprehensive Diabetes Care (5 numerators), Controlling High Blood Pressure, Lead Screening for Children, PPC – Postpartum Care Visits, Weight Assessment and Counseling for Children and Adolescents (all 3 numerators), Well Child Visits – 15 months, and Well Child Visits – Ages 3-6 Years.</p> <p>HK Performance Measures presenting opportunities for improvement included: Adult Counseling for Nutrition and Physical Activity; Adolescent Risk Screening; Prenatal Screening and Counseling and Adolescent Well Care for the children with special health care needs (CSHCN) population.</p> <p>The PIPs were continued and PIP proposals for 2014 were submitted.</p> <p>Twenty-eight provider sites were audited for compliance with medical record keeping standards and only 1 site failed the assessment. Key</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>involve BH concerns.</p> <p>A provider satisfaction survey was fielded in 2012. The survey demonstrated that areas of concern included: resolution of inquiries, claims payment process, service, and the authorization process. Interventions include: training call center staff, educating providers on policies and procedures, promoting directprovider.com, publishing information in the provider newsletter, and increasing outreach visits to providers.</p> <p>The Health Outcomes Survey is planned for 2013.</p>		<p>aggregate findings showed opportunities related to documentation of BMI; documentation of current medications; reports reviewed and initialed; and recording immunization status.</p> <p>The top 3 quality referrals were related to surgical site infections, treatment plan issues, and delay in treatment or diagnosis. The number of referrals that resulted in a confirmed Quality of Care finding was not reported. Overall provider satisfaction was rated at 2.8 out of 5 points, < the goal of 3.</p> <p>Opportunities identified for 2014 by Coventry included: Improving access and availability of care: increase network providers; educate providers regarding availability standards and members about transportation options.</p> <p>Reduce over-utilization of the ED: continue the PIP in progress. The other actions described are not interventions and are limited to meetings, analysis and trending of data, and tracking</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>over-utilizers.</p> <p>Major depression: increase member and provider awareness and monitor medication compliance. Specific interventions are not described.</p> <p>Investigate Quality of Care (QOC) referrals and Adverse Events (AE): improving the process and possible focus study.</p> <p>Continuity of Care/Hospital Readmissions: collaboration between QI and concurrent review staff and implementation of a PIP.</p> <p>ADHD: collaboration with MHNet to develop a PIP.</p> <p>EPSDT: increase member and provider knowledge and collaborate with high-volume pediatric practices.</p> <p>Provider and Member Satisfaction: Administer surveys to define goals. No specific areas of satisfaction to be targeted were identified and planned interventions were not described.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>HEDIS: evaluate 2014 rates to determine where to focus improvement efforts. Specific measures were not identified.</p> <p><u>Recommendation for Coventry</u> Based on the 2013 findings across HEDIS, the HK Performance Measures, medical record documentation assessment, access and availability surveys, quality of care referrals, and satisfaction surveys, Coventry should evaluate 2014 performance and focus efforts on the following, where needed: Well care visits for all age groups: 15 months, ages 3-6 years and adolescents.</p> <p>Preventive services for children and adolescents: immunizations and lead screening; documentation of immunizations in the medical record; risk screening for adolescents; and measurement and documentation of BMI/percentile and counseling for nutrition and physical activity.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Prenatal risk screening and counseling; availability of 3rd trimester visits; and postpartum visits and screening for postpartum depression.</p> <p>Care for members with diabetes.</p> <p>Cervical cancer and Chlamydia screening.</p> <p>Surgical site infections.</p> <p>After-hours telephone access.</p> <p>Overall provider satisfaction.</p> <p>Member satisfaction with shared decision-making and the health plan overall.</p> <p>Based on findings presented at the QMAC meetings, Coventry should address the availability of member materials in Spanish. Since the QMAC requested materials in Spanish, these should be made available routinely.</p>	
21.3 External Quality Review				



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>Substantial - The QI Program Description states that the plan will actively participate in an external independent review performed by the designated External Quality Review Organizations (EQRO), including providing the EQRO with access to site, information, documentation and data. Following an EQRO review the CCKY will review the EQRO report, provide comments for improvement, and implement corrective actions as recommended by the EQRO.</p> <p>During the onsite review, CCKY was cooperative and helpful in providing documentation requested for clarification and in answering related questions. CCKY posted all follow-up documentation timely, most during the onsite.</p> <p>For some of the file reviews (Credentialing, HRA, Service Plans) some evidence/supporting documentation was not in the files or available. See the respective tools for detailed findings.</p> <p>In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely.</p> <p><u>Recommendation for CCKY</u> In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain</p>	<p>Full</p>	<p>Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which contains an action item to ensure all required activities are in place and to provide requested information.</p> <p>The MCO has participated in all EQRO activities, providing documentation, data and medical records when necessary.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>the information.</p> <p>MCO Response: As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.</p>			
<p>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.</p>	<p>Full - The QI Program Description states that CCKY will actively participate and make available all data, clinical and other records/reports to the state Medicaid agency for EQR activities.</p> <p>CCKY cooperated and participated in the current compliance review, PIP validation, PM validation, requests for data and records for focused studies and other EQRO tasks and was cooperative with recommendations and suggestions.</p> <p>For the onsite review, staff was readily available, helpful and responsive.</p>	Full	<p>Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which contains an action item to ensure all required activities are in place and to provide requested information.</p> <p>The MCO has participated in all EQRO activities, providing documentation, data and medical records when necessary.</p> <p>The MCO fully cooperated with the compliance review, submitting documents, data, and records; making staff available; and providing follow-up documentation.</p>	
21.4 EQR Administrative Reviews				



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	<p>Substantial - As described above, CCKY assisted in EQRO reviews and evaluation. There were some issues related to requested files.</p> <p>In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely.</p> <p><u>Recommendation for CCKY</u> In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.</p> <p>MCO Response: As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.</p>	Full	<p>Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014 Work Plan, which contains an action item to ensure all required activities are in place and to provide requested information.</p> <p>The MCO fully cooperated with the compliance review, submitting documents, data, and records; making staff available; and providing follow-up documentation.</p>	
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the	Substantial - As noted previously and in the QI Program Description, CCKY provided pre-site documentation as requested for the compliance review. There were some issues, documented above, with file review documentation (Credentialing, HRA, and Service Plans).	Full	Addressed in the 2014 QI Program Description, on page 17, under External Quality Review and in the 2014.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>CCKY also cooperated with submission of data, records, and documents for other EQR activities, including PIP validation, PM validation, and focused studies.</p> <p>In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely.</p> <p><u>Recommendation for CCKY</u> In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.</p> <p>MCO Response: As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.</p>		<p>Coventry fully cooperated with the compliance review, submitting documents, data, and records; making staff available; and providing follow-up documentation.</p> <p>In addition, the MCO provided all necessary documentation for the 2014 Detailed technical Report production, and has provided documentation for the upcoming 2015 report.</p>	
21.5 EQR Performance				
<p>If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding</p>	<p>Full - For the prior compliance review, CCKY provided responses for findings that were less than fully compliant, as required. In addition, CCKY revised its PIP proposals in response to EQR</p>	Minimal	<p>Addressed in the 2014 QI Program Description, on page 17, under External Quality Review.</p>	<p>Coventry will address all prior deficiencies, and for the current review, ensure that all deficiencies are</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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:	recommendations.		<p>For the prior compliance review, Coventry provided responses to the preliminary findings and the information was considered in making the final review determinations.</p> <p>Coventry submitted corrective action plans (CAPs) to DMS. DMS reviewed and approved the CAPs.</p> <p>Coventry did not fully address all of the prior deficiencies. For the 2015 compliance review, there are multiple domains that include deficiencies that have not been resolved since the 2014 and/or the 2013 review.</p>	<p>fully addressed and resolved within the contract-required time frame (6 months).</p> <p>A compliance review work plan will be created to ensure proper and timely follow up is addressed.</p>
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - CCKY designated staff liaisons for follow-up for the EQR activities and was cooperative with recommendations and requests.	Full	<p>Addressed in the 2014 QI Program Description, on page 17, under External Quality Review.</p> <p>Coventry assigned dedicated Compliance staff to serve as the EQRO liaison. The staff provided follow-up documentation necessary for the onsite review.</p>	
B. Inform the Contractor's Quality	Full - The QI Work Plan and quarterly reports document that the	Full	Addressed in the 2014 QI Work Plan,	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and	Quality Manager informs the EQIC Committee of EQRO findings and develops, implements and monitors a corrective action plan. The QI Work Plan indicates that the prior compliance review report was shared with EQIC in May 2013.		<p>which indicates that the Quality Manager informs the EQIC Committee of EQRO findings and develops, implements and monitors a corrective action plan.</p> <p>Evidenced in the QI Work Plan which indicates that the prior compliance review report was shared with EQIC in May 21, 2014 and in the EQIC meeting minutes.</p>	
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 - The QI Program Description states that CCKY will submit a Corrective Action Plan, within the timeframes established by the EQRO, to resolve any performance or quality of care deficiencies identified during any ongoing monitoring and assessment activities of the EQRO. CCKY acted accordingly for the prior compliance review.	Minimal	<p>Addressed in the 2014 QI Program Description, on page 17, under External Quality Review.</p> <p>According to DMS, Coventry submitted corrective action plans (CAPs) for the majority of deficiencies but initially refused to submit a CAP for the Health Risk Assessment domain. DMS reviewed and approved the CAPs.</p> <p>Coventry did not fully address all of the prior deficiencies. For the 2015 compliance review, there are multiple domains that include deficiencies that have not been resolved since the 2014 and/or the 2013 review.</p>	<p>Coventry will address all prior deficiencies, and for the current review, ensure that all deficiencies are fully addressed and resolved within the contract-required time frame (6 months).</p> <p>A compliance review work plan will be created to ensure proper and timely follow up is addressed.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for Coventry</u> Coventry should ensure that all prior deficiencies are fully addressed, and for the current review, ensure that all deficiencies are fully addressed and resolved within the contract-required time frame (6 months).</p>	
<p>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</p>	<p>Full - The QI Program Description states that CCKY will participate in the annual external quality review, including implementing corrective actions as per recommendations.</p> <p>The QI Work Plan incorporates cooperation with EQR activities. The QI Work Plan includes resubmission of PIP proposals based on EQR recommendations and formation of interdepartmental work groups to conduct PIPs.</p> <p>CCKY has followed EQRO recommendations related to PIPs, focused studies, and compliance findings.</p>	Minimal	<p>Addressed in the 2014 QI Program Description, on page 5, under Objectives, and on page 17.</p> <p>The 2014 QI Work Plan contains action item to ensure all required EQR activities are in place and to provide requested information.</p> <p>Some of the 2013 and 2014 compliance review findings of Minimal and Non-Compliance for varied domains and a number of review elements have not been addressed and/or resolved.</p> <p>Additionally, some recommendations related to the PIPs have not been addressed by the MCO. The two Interim PIPs required a Corrective</p>	<p>Coventry will attach action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings to the work plan.</p> <p>Coventry will address all DMS and IPRO recommendations related to the compliance review and for the PIPs.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Action Plan (CAP) based on the scores achieved. A conference call with DMS, IPRO and MCO was held and the MCO submitted a CAP to DMS.</p> <p><u>Recommendation for Coventry</u> The MCO should include the specific compliance findings and corrective actions with the target completion date in the QI Work Plan to ensure that all findings are fully addressed.</p>	
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	NA - CCKY has not indicated disagreement with EQRO findings.	Full	Coventry submitted its responses the prior review findings and the responses were considered when making the final review determinations.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that	Full - CCKY submitted the CCKY QI Work Plan 2013 (the Work Plan).	Full	<p>Includes review of MCO Report #17 QAPI Work Plan</p> <p>Addressed in the 2014 QI Program Description and 2014 QI Work Plan which includes a task for submission of the QI Work Plan to DMS annually and quarterly submissions of QI Work Plan updates.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Evidenced in the 2014 QI Work Plan which states that the 2014 QI Work Plan was submitted July 2014.</p> <p>Evidenced in Coventry's submission of Report #17 each quarter in 2014.</p>	
<p>outlines the scope of activities and</p>	<p>Full - The QI Work Plan lists activities with rationale for selection and corresponding NCQA accreditation requirement. The QI Work Plan includes objectives, list of tasks, responsible staff, and benchmarks, due dates, status, and comments on project status.</p> <p><u>Recommendation for CCKY</u> CCKY should include all action plans described in the Annual Evaluation, listing each by topic.</p>	<p>Minimal</p>	<p>Addressed in the 2014 QI Work Plan includes required elements: the activities with rationale for selection and corresponding NCQA accreditation requirement; as well as objectives, responsible staff, benchmarks, due dates, status, and comments on project status.</p> <p>This element received a score of Minimal because the recommendation from the prior year was not addressed.</p> <p><u>Recommendation for Coventry</u> Coventry should include all action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings.</p>	<p>Coventry will attach action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings to the work plan.</p>
<p>the goals,</p>	<p>Full - The QI Work Plan includes specific goals.</p>	<p>Full</p>	<p>The 2014 QI Work Plan contains goals</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			based on contract requirements, internal and industry standards, and Quality Compass percentiles.	
objectives, and	Full - The QI Work Plan includes specific objectives.	Full	The 2014 QI Work Plan contains objectives for each activity.	
timelines for the QAPI program.	<p>Substantial - The QI Work Plan incorporates start and due dates but it is not clear whether these are the target dates for completion or completion dates. The work plan does not include the dates when required reports were submitted to DMS and the internal committees.</p> <p>For the prior review, IPRO recommended that CCKY include timelines and completion dates in the QI Work Plan. As noted above, this was partially addressed as it is not evident if the dates are target or actual completion dates.</p> <p><u>Recommendation for CCKY</u> CCKY should label the dates as start, target, and actual completion dates and include submission dates for the required committee reports and DMS.</p> <p>MCO Response: The work plan for 2014 captures a Start date and a due date. A column for 'Completion Date' has been added for clarity at the request of IPRO. Additionally, the comments section will outline the report submission date to DMS and a report schedule will be attached to the work plan to capture specific</p>	Full	The 2014 QI Work Plan includes start and due dates, a status column, and a location for comments.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	deliverable dates for QMUM and EQIC reports.			
<p>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.</p>	<p>Full - The 2012 Annual Evaluation includes revised goals, objectives, and interventions for the coming year. Committee minutes provide evidence of tracking and trending quality improvement activities, survey results, grievances and appeals, performance measures, and adverse events.</p> <p>Since CCKY will report its first year HEDIS rates in 2014, there is no information on QI activities related to HEDIS performance in the 2012 QI Evaluation. However, CCKY provided other documents onsite that described the HEDIS measures being targeted for improvement and the related initiatives.</p>	Substantial	<p>Addressed in the 2013 QI Evaluation which includes revised goals, objectives, and interventions for the coming year.</p> <p>Committee minutes provide evidence of tracking and trending quality improvement activities, survey results, grievances and appeals, performance measures, and adverse events.</p> <p>In the 2013 QI Evaluation, Coventry addresses interventions targeting HEDIS measures on pages 39-40. However, many of the actions described are focused on availability of data and data collection. For instance, educating providers on HEDIS specifications, implementing HEDIS reporting, developing a supplemental database, and obtaining correct provider contact information for medical record retrieval.</p> <p>Opportunities identified for 2014 by Coventry included: Improving access and availability of care: increase network providers;</p>	<p>Coventry will include specific HEDIS, HK Performance Measures and CAHPS items that will be prioritized and targeted in next year on the annual eval and appropriate action/work plans.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>educate providers regarding availability standards and members about transportation options.</p> <p>Reduce over-utilization of the ED: continue the PIP in progress. The other actions described are not interventions and are limited to meetings, analysis and trending of data, and tracking over-utilizers.</p> <p>Major depression: increase member and provider awareness and monitor medication compliance. Specific interventions are not described.</p> <p>Investigate Quality of Care (QOC) referrals and Adverse Events (AE): improving the process and possible focus study.</p> <p>Continuity of Care/Hospital Readmissions: collaboration between QI and concurrent review staff and implementation of a PIP.</p> <p>ADHD: collaboration with MHNet to develop a PIP.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>EPSDT: increase member and provider knowledge and collaborate with high-volume pediatric practices.</p> <p>Provider and Member Satisfaction: Administer surveys to define goals. No specific areas of satisfaction to be targeted were identified and planned interventions were not described.</p> <p>HEDIS: evaluate 2014 rates to determine where to focus improvement efforts. Specific measures were not identified.</p> <p><u>Recommendation for Coventry</u> Based on the 2013 findings across HEDIS, the HK Performance Measures, medical record documentation assessment, access and availability surveys, quality of care referrals, and satisfaction surveys, Coventry should consider focusing its efforts on the following: Well care visits for all age groups: 15 months, ages 3-6 years and adolescents.</p> <p>Preventive services for children and</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>adolescents: immunizations and lead screening; documentation of immunizations in the medical record; risk screening for adolescents; and measurement and documentation of BMI/percentile and counseling for nutrition and physical activity.</p> <p>Prenatal risk screening and counseling; availability of 3rd trimester visits; and postpartum visits and screening for postpartum depression.</p> <p>Care for members with diabetes.</p> <p>Cervical cancer and Chlamydia screening.</p> <p>Surgical site infections.</p> <p>After-hours telephone access.</p> <p>Overall provider satisfaction.</p> <p>Member satisfaction with shared decision-making and the health plan overall.</p> <p>Based on findings presented at the</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>QMAC meetings, Coventry should address the availability of member materials in Spanish. Translated MCO Member materials are required when ≥ 10% of members speak a language other than English, or when requested by a member. Since the QMAC requested Spanish language materials, Coventry should make these routinely available.</p> <p>Recommendation for Coventry In the QI Evaluation, the MCO should define the specific HEDIS, HK Performance Measures and CAHPS items that will be prioritized and targeted in next year.</p>	
<p>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;</p>	<p>Full - The QI Program Description states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the EQIC. The EQIC responsibilities include review and approval of the QI Program Description and QI Work Plans, including updates.</p> <p>Discussion and approval of the QI Work Plan and QI Program Description is evident in EQIC minutes.</p>	<p>Full</p>	<p>Addressed in the 2014 QI Program Description which states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the EQIC.</p> <p>The EQIC responsibilities include review and approval of the QI Program Description and QI Work Plans, including updates.</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Discussion and approval of the 2014 QI Work Plan and 2014 QI Program Description is evident in EQIC minutes.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	<p>Full - As indicated above, the Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of CCKY.</p> <p>The QI Program Strategy states that the Board of Directors (BOD) delegates oversight of the Quality Improvement and Management program to the Executive Quality Improvement Committee.</p> <p>The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer and includes members of senior leadership.</p> <p>The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight.</p> <p>The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings.</p> <p>The Vice President of Quality Improvement (Medical Director) is the senior executive responsible for the Quality Improvement Program according to the QI program description. The Regional Vice President of Quality Improvement provides direction on</p>	Full	<p>The 2014 QI Program Description, on page 6, states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the MCO's CEO and to EQIC.</p> <p>The EQIC responsibilities include review and approval of the QI Program Description and QI Work Plans, including updates (on page 9).</p> <p>The MCO's Chief Medical Officer has overall responsibility and oversight of the QI Program (on page 8).</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.			
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;	<p>Full - The EQIC Description, committee descriptions, and Organizational Chart provided by CCKY show that the EQIC reviews the QI Program Description, QI Work Plan and updates, and the Annual QI Evaluation, and is responsible for monitoring delegated services and the activities of sub-committees.</p> <p>CCKY also provided quarterly committee reports and monthly EQIC meeting minutes for review.</p> <p>The Board of Directors reviews the QI Program Description, QI Work Plan and Annual QI Evaluation annually.</p> <p>The QI Program Strategy indicates that the EQIC reports to the Board of Directors. The EQIC approved the QI Program Description and QI Work Plan on 5/22/13 as reflected in committee minutes and the QI Work Plan. CCKY report on 4/30/13 showed EQIC will receive biannual reports from each committee and that programs not meeting goals will be discussed in committee.</p> <p>There is documentation that the EQIC oversaw all audits, surveys, corrective action plans, NCQA accreditation preparation, QI initiatives/studies, and required QI reports and summaries.</p>	Full	<p>Addressed In the EQIC Description which indicates that the EQIC reviews the QI Program Description, QI Work Plan and updates, and the Annual QI Evaluation, and is responsible for monitoring delegated services and the activities of sub-committees.</p> <p>Evidenced in quarterly committee reports and monthly EQIC meeting minutes.</p>	
review on an annual basis of the QAPI program; and	Full - CCKY provided the 2012 Annual QI Evaluation report. Quarterly reports and meeting minutes show that EQIC reviewed	Full	The 2014 QI Program Description, on page 6, states that the Board of	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	and approved the 2012 Annual Evaluation, QI program description and QI Work Plan.		<p>Directors is responsible for the quality of care and delegates oversight of the QI Program to the MCO's CEO and to EQIC.</p> <p>Addressed In the EQIC Description which indicates that the EQIC reviews the QI Program Description, QI Work Plan and updates, and the Annual QI Evaluation.</p> <p>EQIC minutes demonstrate that the committee reviewed and approved the 2013 Annual Evaluation, 2014 QI Program Description and 2014 QI Work Plan at its May 21, 2014 meeting.</p>	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	<p>Full - The 2012 Annual QI Evaluation highlights opportunities for improvement and action plans for monitored topics within the QAPI program.</p> <p>The 2013 Work Plan is organized by rationale for selection, including accreditation requirement, contract requirement, or EQRO review findings.</p> <p>The QI Work Plan now includes a column for comments where descriptive updates are provided.</p> <p>Additionally, committee meeting minutes provide detailed information.</p>	Minimal	<p>Addressed in the 2014 QI Work Plan which is organized by rationale for selection, including accreditation requirement, contract requirement, or EQRO review findings, and includes a column for comments where descriptive updates are provided. Reference is made to the HEDIS/HK/ EPSDT Work Plan which contains more detailed information for those measures.</p> <p>Some findings of Minimal and Non-</p>	<p>Coventry will attach action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings to the work plan.</p> <p>Coventry will address all DMS and IPRO recommendations related to the compliance review and for the PIPs.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>For the prior review, IPRO recommended that, in the future, CCKY should ensure these all areas of concern and the activities are included in the QI Work Plan. For the current review, although EPSDT initiatives were not included in the QI Work Plan, CCKY indicated that there is a dedicated work plan for EPSDT.</p> <p><u>Recommendation for CCKY</u> CCKY should consider referencing the EPSDT work plan in the QI Work Plan or including as an attachment.</p>		<p>Compliance from the 2013 and 2014 for varied domains and elements reviews have still not been addressed and/or resolved.</p> <p>Additionally, some recommendations related to the PIPs have not been addressed by the MCO. A conference call with DMS, IPRO and MCO was held and the MCO submitted a CAP to DMS.</p> <p><u>Recommendation for Coventry</u> Coventry should include all action plans described in the QI Evaluation, listing each by topic, as well as the specific corrective actions related to the compliance findings.</p> <p>Coventry should ensure that all DMS and IPRO recommendations related to the compliance review and for the PIPs are fully addressed.</p>	
<p>The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.</p>	<p>Full - The QI Program Description states the Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of CCKY. The BOD delegates oversight of the Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC).</p>	<p>Full</p>	<p>The 2014 QI Program Description states that the BOD of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program.</p> <p>The BOD delegates oversight and</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer, and includes members of senior leadership.</p> <p>The EQIC implements, monitors and evaluates quality improvement initiatives and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings.</p> <p>The Vice President of Quality Improvement (Medical Director) is the senior executive responsible for the Quality Improvement Program. The Regional Vice President of Quality Improvement provides direction for the activities of the Quality Improvement Department.</p> <p>The Regional Director/Manager of Quality directs the operational components of the QI Program.</p> <p>The Program Strategy indicates that the Quality Management/Utilization Management Committee (QM/UM) provides clinical input and physician review of QI and UM programs and makes recommendations to the EQIC.</p> <p>The Vice President of Medical Affairs chairs the QM/UM committee. Committee meeting minutes reflect clinical review of the QI and UM programs.</p>		<p>direction of the Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC).</p> <p>The EQIC implements, monitors and evaluates quality improvement initiatives and programs; quality of care and services; credentialing; utilization management and delegated services oversight.</p> <p>The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings.</p>	
The committee structure shall be interdisciplinary and be made up of both	Full - The quarterly reports, and committee meeting minutes demonstrate that the EQIC is comprised of senior leadership staff	Full	Addressed in the EQIC Description, which states that the EQIC is	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>across the organization participate in QI Program activities. These include the VP of Medical Affairs and the Health Services, Compliance, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals departments.</p> <p>Participation across the organization is evident in committee meeting minutes. The QM/UM Committee is a subcommittee of the EQIC that includes physician representation. The CCKY medical directors, three network providers and MHNet are represented on the committee. QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation.</p> <p>In the prior review, IPRO found that CCKY was still seeking OB/GYN provider(s) to participate in the committee. For the current review, CCKY still had not located an OB/GYN to join the committee. Onsite staff indicated that potential participants were being sought from Partners in Women's Health in Louisville and the Department of OB/GYN at UK in Lexington.</p>		<p>comprised of senior leadership staff across the organization participate in QI Program activities. These include the CEO and Medical Director, and the Health Services, Government Relations, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals departments.</p> <p>Evidenced in the EQIC meeting minutes, which document participation across the organization.</p> <p>Addressed in the QM/UM Committee description which indicates that the QM/UM Committee is a subcommittee of the EQIC that includes physician representation. The Coventry Medical Directors, three network providers and MHNet are represented on the committee.</p> <p>QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for Coventry</u> Coventry should consider creating Committee Charters as addendums to the QI Program Description. The Charters should include: Overall Roles and Responsibilities Specific responsibilities Meeting frequency Quorum Members of the Committee Designate voting/non-voting members Reports Annual Goals</p>	
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.	<p>Full - CCKY provided monthly committee meeting minutes for the EQIC and QMUM committees. These were included in the quarterly reports.</p> <p>The activities of the EQIC were documented in the comments area of the QI Work Plan.</p>	Full	<p>Coventry provided monthly committee meeting minutes and Report #21 for the EQIC and QMUM committees.</p> <p>The minutes and Report #21 were submitted to DMS quarterly, as required.</p>	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of	<p>Full - As seen in the EQIC Description, provider and subcontractor QI activities are reported to the EQIC annually or more often.</p> <p>The EQIC is responsible for integration of activities related to providers as well delegation oversight. Minutes of the QM/UM Committee include multiple examples of QI activities relevant to</p>	Full	<p>Addressed in the EQIC Description, which indicates that provider and subcontractor QI activities are reported to the EQIC annually or more often. The EQIC is responsible for integration of activities related to</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>providers and subcontractors, such as clinical guideline dissemination, disease management programs, prescription policies, creation of EPSDT toolkits and audit forms, peer review, provider survey results, authorizations/denials, professional organization recommended guidelines, PIPs, HRA reports, HEDIS results and benchmarks, QOC reports, Medical record review audits, MHNet collaborations, and plans for hospital site visits to discuss criteria for utilization reports. The Provider Manual includes requirements for provider agreement to participate in quality improvement activities including site visits and medical record audits and encounter record submission. These are included in the Provider Manual for delegated services as well.</p> <p>As documented in the quarterly CCKY reports, the Compliance Committee oversees subcontractor relationships. The Delegation Oversight Committee reports to EQIC and monitors the performance of subcontractors.</p> <p>Behavioral health has its own quality program, but appears well integrated with physical health as described above.</p>		<p>providers as well delegation oversight.</p> <p>Evidenced in the QM/UM Committee meeting minutes which included examples of QI activities relevant to providers and subcontractors.</p> <p>Evidenced in Coventry's quarterly reports which indicate that the Compliance Committee oversees subcontractor relationships. The Delegation Oversight Committee reports to EQIC and monitors the performance of subcontractors.</p> <p>Communicated to subcontractors in Contract section Appendix B State-Specific Addendum – Kentucky.</p> <p>Communicated to providers in</p>	
<p>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.</p>	<p>Full - CCKY's QI Work Plan, QI Program Description and UM Program Description include Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities.</p> <p>As of November 1, 2013, under Aetna, the CCKY Credentialing Committee was retired and Aetna National Quality Management and Measurement Department assumed responsibility. CCKY will continue local management of the issues list, contracting and</p>	Full	<p>Addressed in the 2014 QI Program Description and 2014 UM Program Description which indicate that Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities as well as the committee descriptions.</p> <p>Evidenced in the EQIC meeting</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>other provider relations functions and delegation oversight agreements in the Network Management Department. Delegate auditing will be shared between CCKY and Aetna. However, provider quality of care issues and overall performance will be incorporated in re-credentialing. Since the MCO is new, no providers have gone through re-credentialing.</p> <p>CCKY continues its transition to Aetna national processes and will be fully integrated in 2015.</p>		<p>minutes, which document participation across the organization.</p> <p>Evidenced in the QM/UM minutes which identify membership from across the organization.</p> <p>Coventry also submitted a variety of quality program documents from CoventryCares of Nebraska, including Medicaid Medical Advisory Committee meeting agendas, minutes and reports and Quality Management Oversight Committee meeting agendas, minutes and reports. These appear to be examples of the Aetna Better Health process for QI oversight.</p>	
<p>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</p>	<p>Full - At the corporate level, the Board of Directors and the Board of Managers delegate responsibility for the quality improvement process to the Corporate Quality Improvement Committee (CQIC). CCKY's Chief Medical Officer (CMO) has overall responsibility for the Corporate QI Program. The corporate Medical Director is the designated physician for the QI Program, has oversight of the program and is an active member of the CQIC. The Corporate Vice President of QI leads the activities in the QI Department. The Corporate Sr. Vice President and other Corporate QI staff participate in the QI Program.</p>	<p>Full</p>	<p>Addressed in the QI Program Description which reports that the BOD delegates responsibility for the quality improvement process to the EQIC and CEO. Coventry's Medical Director has overall responsibility for the QI Program and is an active member of the EQIC which is chaired by the MCO's CEO.</p> <p>Addressed in the QI Program</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>At the regional level, the Regional Quality Vice President and Regional QI Coach/Chief Executive Officer have overall responsibility for the Regional QI Program. The Regional QI Vice President reports directly to the Regional QI Coach. The Regional Quality Improvement Director manages the day-to-day activities of the QI Program and reports directly to the Regional Vice President of Quality Improvement. Regional QI Department Staff are responsible for implementation, analysis and reporting on QI activities. Health Plan Senior Medical Directors participate in the Regional Quality Improvement Committee.</p> <p>Locally, the CMO and VP of Medical Affairs are responsible for directing the QI programs. Medical Directors are responsible for medical management programs. The Director of Health Services ensures staffing levels and staff competencies. Managers and supervisors oversee day-to-day activities. QI Program staff includes clinical and professional staff supported by Medical Directors and staff from the following departments: UM and QI, Network Management, Provider Relations, Compliance, IT support and Member Services. Analytic Resources encompass multiple experienced QI personnel, data analysts, certified coders, Information Systems and actuarial experts.</p> <p>Behavioral health QI activities are integrated into the QI program with a doctorate-level behavioral health practitioner serving as a member of the Corporate QI Committee and the Regional Physician Advisory Committee.</p> <p>The EQIC committee is comprised of a multidisciplinary</p>		<p>Description, C. National and Regional/Local Resources, pages 12 - 14.</p> <p>Locally, the CMO and VP of Medical Affairs are responsible for directing the QI programs. Medical Directors are responsible for medical management programs. The Director of Health Services ensures staffing levels and staff competencies. Managers and supervisors oversee day-to-day activities.</p> <p>Local QI Program staff includes clinical and professional staff supported by Medical Directors and staff from the following departments: UM and QI, Network Management, Provider Relations, Compliance, IT support and Member Services.</p> <p>Analytic Resources encompass multiple experienced QI personnel, data analysts, certified coders, Information Systems and actuarial experts</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>membership, including: Medical Directors, BH, pharmacy, Network Management, Service Operations, and Health Services Directors, and Managers of Appeals, Compliance, and Provider relations.</p> <p>This structure will likely change for 2015 as CCKY becomes more integrated into the Aetna model.</p>			
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	<p>Addressed in the 2014 QI Work Plan, which includes a task for submission to DMS.</p> <p>Evidenced in the 2014 QI Work Plan which notes annual submission in July 2014 and in Report #84.</p> <p>Submission of quarterly updates is documented in Report #17, submitted quarterly to DMS as required.</p>	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be	Full - The 2012 Annual Evaluation and quarterly reports provide evidence of ongoing monitoring of quality of care. The 2012 Annual Evaluation describes monitoring activities and results focused on special needs, acute or chronic physical or behavioral conditions, high volume, and high risk populations, in the population analysis. The population analysis highlights opportunities for improvement and action plans.	Full	<p>Includes review of MCO Report #23 Evidence Based Guidelines for Practitioners</p> <p>Addressed in the 2014 QI Program Description, on page 2 and in the Goals (page 3) and Objectives (pages 4-6).</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>The QMUM committee minutes show evidence of development of practice guidelines, development of performance improvement goals and case management initiatives, oversight of PIPs, utilization reports, grievances and appeals, and nurse line protocols and reports. There is evidence of monitoring of quality of care concerns and sentinel events in committee minutes.</p> <p>The 2012 Annual Evaluation documents that adverse events and potential quality of care concerns are tracked, trended, and reported annually.</p> <p>The plan has analyzed member demographic data and diagnosis prevalence to prioritize quality improvement activities and focus disease management programs as per the 2012 Annual Evaluation.</p> <p>The QI Work Plan includes monthly monitoring of customer service and pharmacy call metrics (abandonment, speed of answer), nurse line calls, and utilization management calls (prior authorization), and these appear to be actively monitored.</p> <p>The plan coordinates improvement initiatives with MHNNet, such as PIPs covering Major Depression, ED Utilization, and hospital readmissions. Other BH collaborations include prevention program focused on ADHD, Anxiety, Depression in the Older Adult, and post partum depression.</p> <p>In 2012, CCKY conducted a review of medical record keeping practices. Two indicators did not achieve the goal of 80%</p>		<p>Evidenced in the 2013 QI Evaluation and quarterly Work Plan updates, Report #17.</p> <p>On page 69, the 2013 QI Evaluation indicates that all clinical, preventive and BH guidelines are reviewed on an annual basis and are posted on the Coventry web site and communicated to the provider network via fax blast.</p> <p>The 2013 QI Evaluation and quarterly reports show ongoing monitoring of quality of care and describe monitoring activities and results focused on special needs, conditions, and other populations.</p> <p>Evidenced in the QM/UM committee minutes which contain evidence of developing CPGs; setting performance improvement goals; conducting case management initiatives; overseeing progress of PIPs; reviewing utilization reports, grievances and appeals data, and nurse line protocols and reports. There is also evidence of monitoring quality of care concerns and sentinel events.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>compliance: documenting BMI and Advance Medical Directives. CCKY implemented interventions and the follow-up review was conducted.</p> <p>In 2013, CCKY reported its first HEDIS and CAHPS rates. On site, CCKY provided a summary of the HEDIS measures to be targeted.</p> <p>In the prior review, IPRO recommended that CCKY should continue work on improving trending of quality of care concerns by improving categorization and monitoring detailed types of concerns.</p> <p>The 2012 QI Evaluation indicated that CCKY improved its processes for Adverse Events (AE) and Quality of Care (QOC) issues. P/P and training improved the MCO's ability to effectively refer, categorize, review and analyze AEs and QOCs. As a result, CCKY identified that post-up infections were an issue. CCKY conducted a focused study and implemented an improvement plan.</p>		<p>Evidenced in the 2014 QI Work Plan which indicates that review of PH CPGs was completed in September 2014 and review of BH CPGs in April 2014.</p> <p>Evidenced in Report #23 Evidence Based Guidelines for Practitioners, which describes the guidelines used by the MCO and updates to guidelines completed each quarter, if any.</p>	
<p>B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.</p>	<p>Full - Clinical and preventive guidelines are included in the QI Program Description, EQIC and QM/UM committee minutes. QMUM meeting minutes from July 18, 2013 indicate a review of Behavioral Health Guidelines. Meeting minutes from April 18, 2013 indicate review and edit of Short-Term Chronic Opiate policy, AAP or ADA Dental Health Screenings, and review of CDC changes to immunization schedules; May 16, 2013 shows approval of the "Preventive Health Guide Lines"; December 19, 2013 indicates review of Clinical Policy Updates.</p>	<p>Full</p>	<p>Addressed in the 2014 2QI Program Description, page 6 Objectives, pages 8-9 Health Plan Structure, and pages 10-11, QM/UM Committee.</p> <p>Coventry conducted measurement of CPG compliance and reported the results to the QM/UM Committee on May 15, 2014.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>Policy updates and clinical guidelines are posted on the online provider portal: directprovider.com. Updates are also communicated through newsletters as evidenced in Provider Newsletter volume 1 issue 2.</p> <p>Quarterly report 1/30/14 indicates that an annual medical record audit was performed and improvement efforts were implemented for documentation of BMI and Advance Directives. Additionally, CCKY reported its first HEDIS rates in 2013. HEDIS is used to evaluate provider compliance with selected guidelines.</p>			
<p>Areas identified for improvement shall be tracked and corrective actions taken as indicated.</p>	<p>Full - As indicated above, CCKY conducted interventions related to documentation of BMI and Advance Directives with a 6-month follow-up review.</p> <p>HEDIS measures were first reported in 2013 and onsite, CCKY provided documentation regarding the HEDIS measures that will be targeted for improvement (noted previously in this report). Gap reports posted to directprovider.com inform providers of members with gaps in services based on monthly monitoring of selected HEDIS measures and ED utilization has been added. Additionally, CCKY met with Aetna corporate regarding provider profiling initiatives and High Performance Networks (based on providers/groups that exceed goals).</p> <p>As per QM/UM minutes, providers with referrals for AEs/QOCs are being tracked and trended, and a focused study with subsequent interventions was completed.</p> <p>Regarding the HRA completion rate, please see the QAPI</p>	<p>Full</p>	<p>Addressed in the 2014 QI Program Description, pages 2-3 Program, page 3 Goals, and pages 4-6 Objectives.</p> <p>Evidenced in the 2014 QI Work Plan, the 2013 QI Evaluation, and the QM/UM and EQIC meeting minutes.</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>Structure and Operations Tool. Areas with opportunity for improvement are noted in the 2012 Annual Evaluation, with associated improvement activities.</p> <p>The Work Plan documents tracking of various improvement activities.</p>			
<p>The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.</p>	<p>Full - EQIC meeting minutes on September 25, 2013 indicate corrective action plan was developed for a vendor as the result of findings on the delegation oversight summary report.</p> <p>Tracking of indicators via monthly HEDIS, PIPs, and performance measures among others is used to evaluate to assess the effectiveness of corrective actions and interventions.</p> <p>The QI Program Description and the 2012 Annual Evaluation state that the Delegation Oversight Committee develops corrective action plans and monitors improvements. MHNet maintains its own Corrective Action Plans.</p>	<p>Full</p>	<p>Addressed in the 2014 QI Program Description, pages 2-3 Program, page 3 Goals, and pages 4-6 Objectives.</p> <p>Evidenced in the 2014 QI Work Plan, the 2013 QI Evaluation, and the QM/UM and EQIC meeting minutes. Evaluating the effectiveness of corrective actions and interventions is evidenced in tracking of indicators via monitoring HEDIS data, monitoring PIPs and performance measures and other methods.</p>	
<p>C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.</p>	<p>Full - The plan's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff.</p>	<p>Full</p>	<p>Addressed in the QI Program Description, pages 7-8 National Structure, pages 8-9 Health Plan Structure, and pages 9-14 Committee Structure.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>The QM/UM committee, which reviews and analyzes clinical data, includes pediatric, internal medicine, hospital and behavioral health members, as well as Case Management, Appeals, Health Services and Pharmacy representation.</p> <p>According to the QI Program Description, there is computer/data and clinical/professional staff at the local plan level and also at the corporate level to augment local staff for QI activities as per the QI Program Description. The behavioral health QI activities include collaboration between MHNet and plan staff.</p>		<p>The MCO's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff.</p> <p>The QM/UM Committee, which reviews and analyzes clinical data, includes members representing pediatrics, internal medicine, hospital, BH, Case Management, Appeals, Health Services and Pharmacy.</p>	
<p>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.</p>	<p>Full - According to the QI Work Plan, the 2013 QI Program Description and annual UM Program Evaluation were submitted to DMS in July 2013. Updates to the QI Program were sent to DMS on a quarterly basis.</p> <p>CCKY PIP topics include: (2103) Major Depression and ED Utilization and (2014) ADHD and Inpatient Readmissions.</p> <p>PIP proposals were revised and submitted based upon EQRO recommendations. 2013 PIPs were approved by DMS on 2/24/2014 and 2014 PIPs were approved by DMS on 3/4/2014.</p>	<p>Substantial</p>	<p>Addressed in Policy and Procedures QI-00 Performance Improvement Projects and the 2014 QI Work Plan, which includes the PIPs as a task.</p> <p>Evidenced in Coventry's submission of Report #90, Report #92 and quarterly Report #19 Performance Improvement Projects.</p> <p>In 2014, one baseline report was submitted late (ADHD PIP – due</p>	<p>Coventry will ensure all PIP reports are submitted in a timely manner to meet deadlines set by DMS.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>9/1/14, received 9/18/14) and one revised proposal was submitted late (Antipsychotic Use PIP- due 12/20/14, received 12/30/14).</p> <p>Coventry PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions and (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes.</p> <p>PIP topics include one BH and one PH annually, as required. Each of the PIP topics was approved by DMS. The 2015 Use of Antipsychotics PIP is a statewide collaborative directed by DMS.</p>	
<p>E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.</p>	<p>Substantial - According to the QI Program Description, CCKY's evaluation of the QAPI Program includes evaluation of utilization and clinical performance data against evidence based practice.</p> <p>The Provider Manual describes clinical guidelines and where to locate them on the plan's website.</p> <p>Guidelines are provided to members in the Member Handbook including EPSDT guidelines, routine testing/screening and cancer screenings. The member newsletters also include guidelines.</p>	<p>Full</p>	<p>Addressed in QI-024 Clinical Practice Guidelines Policy, May 2014, which outlines the adoption and assessment process and in the 2014 2QI Program Description, page 6 Objectives, pages 8-9 Health Plan Structure, and pages 10-11, QM/UM Committee.</p> <p>Evidenced in Report #23 Clinical Practice Guidelines, which is submitted</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>QMUM meeting minutes note review of evidence based clinical guidelines and standards and the committee's input and oversight of disease management guides. These guides refer to guidelines established by professional entities and are available to providers on the website portal.</p> <p>Clinical review guidelines are included in the UM Program Description, which notes that they are available on request and are disseminated on the provider website, provider manual and provider newsletters.</p> <p>In the prior review, IPRO recommended that CCKY consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines. CCKY indicated that this is on hold due to the Aetna merger, which was announced October 2012 and was completed in May 2013, with full integration of CCKY's processes by Q1 2015.</p> <p>Recommendation for CCKY The plan should consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines.</p> <p>MCO Response: As a part of the CoventryCares and Aetna migration, CCKY will adopt the Aetna policy and procedures outlining development, adoption and dissemination of clinical practice guidelines.</p>		<p>to DMS quarterly.</p> <p>Communicated to providers via the Provider Manual which describes clinical guidelines and where to locate them on the MCO's website.</p> <p>Communicated to members in the Member Handbook which includes EPSDT guidelines and recommendations for routine testing/screening and cancer screenings.</p> <p>The member newsletters also advise members regarding guidelines/health recommendations.</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	<p>Full - Disease Management Guides site clinical evidence-based standards as recommended by nationally recognized professional organizations, such as the American Lung Association, National Heart Lung and Blood Institute, American Heart Association, and American College of Cardiology Foundation.</p> <p>QMUM Meeting minutes indicate that the CDC was used as a resource to review immunization updates and the American Academy of Pediatrics and the American Dental Association Dental Screening was reviewed.</p>	Full	<p>Addressed in QI-024 Clinical Practice Guidelines Policy, May 2014, which outlines the adoption and assessment process.</p> <p>Evidenced in QM/UM meeting minutes.</p>	
consider the needs of Members;	<p>Full - Quarterly reports state the purpose of QMAC subcommittee meetings is to interact with members and get their feedback on topics such as quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the Plan.</p> <p>These meetings were held quarterly in four regions. A total of 16 meetings were scheduled for 2013. Representatives from community organizations are present at the meetings to advocate for the needs of members. The EQIC reviewed QMAC reports bi-annually.</p> <p>As per QMAC meeting minutes, there is an exchange of information between the community advocates and the plan about health tips, promotional activities and community events. Also included in the meeting minutes is discussion of concerns about cultural norms and small numbers of providers affecting access to dental care.</p>	Full	<p>Addressed in Policy and Procedure QI 024 Clinical Practice Guidelines Policy May 2014 which states "The topics selected for clinical guidelines development will be related to areas determined to be high risk, high volume and or problem prone areas, with guidelines related to the disease management programs and behavioral health."</p> <p>Evidenced in the 2013 QI Evaluation which includes results of population analyses. These analyses provide a breakdown of member demographics, top 25 diagnoses and special needs categories.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>The 2012 Annual Evaluation described results of population analysis. This analysis performs a breakdown of member demographics, top 25 diagnoses, special needs categories, linguistic assistance, and cultural competencies. Customer service is also analyzed to direct improvements.</p> <p>In 2013, the plan performed the CAHPS survey to assess member satisfaction. The results were used to identify opportunities of improvement according to the CAPHS report and review by EQIC and the Service Advisory Committee (SAC). As per quarterly reports, the SAC oversees evaluation and improvement efforts related to member and provider satisfaction, access, availability, and quality of service.</p>			
developed or adopted in consultation with contracting health professionals, and	<p>Full - The QI Program Description indicates that the QM/UM committee, which includes contracting health professionals, will review guidelines.</p> <p>The QM/UM meeting minutes include discussion of clinical guidelines. Preventive health guidelines were approved by QM/UM as per report 7/30/13. MHNNet reviews behavioral Health guidelines prior to EQIC approval.</p>	Full	<p>Addressed in QI 024 Clinical Practice Guidelines Policy, May 2014, which states "When clinical practice guidelines are developed and additional physician input is needed, draft guidelines are sent to the appropriate medical director for review and recommendations. The guidelines will be shared with the Corporate Quality Improvement Committee (QIC) for final approval."</p> <p>Evidenced in the QM/UM meeting minutes which include discussion of clinical guidelines.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Preventive health guidelines were approved by QM/UM as per report 7/30/13. MHNNet reviews behavioral Health guidelines prior to EQIC approval.	
reviewed and updated periodically.	<p>Substantial - The Work Plan indicates that clinical guidelines are reviewed, updated, and approved annually. The case management and health services teams are primarily responsible. The guidelines are also submitted to the QMUM committee for annual review according to QMUM meeting minutes listed in report 130730.</p> <p>In the prior review, IPRO recommended that CCKY consider policies/procedures regarding development, adoption, dissemination and updating of clinical practice guidelines. As noted previously, CCKY is in the process of integrating into Aetna.</p> <p>MCO Response: As a part of the CoventryCares and Aetna migration, CCKY will adopt the Aetna policy and procedures outlining development, adoption and dissemination of clinical practice guidelines.</p>	Full	<p>Addressed in QI 024 Clinical Practice Guidelines Policy, May 2014, on page 2, which outlines the adoption and assessment process. It states that "CPG's are reviewed and approved biannually by Coventry's Medicaid Advisory Committee (MAC) and Corporate Quality Improvement Committee (QIC)."</p> <p>Evidenced in the QM/UM meeting minutes which include discussion of clinical guidelines.</p> <p>Additionally, Coventry submitted copies of the CPGs that were updated during 2014.</p>	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the	Full - The UM Program Description states that the UM program includes processes to ensure that approved clinical practices national guidelines such as InterQual are applied equitably throughout the plan's provider network. UM evaluates medical	Minimal	For UM and covered services, this is addressed in the UM Program Description which states that the UM Program includes processes to ensure	UM IRR results will be appended to the QMOC minutes. Reporting scheduled has been revised for 2015.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
guidelines.	<p>necessity based upon evidence based medical guidelines and assures that providers are educated on current clinical criteria. The QMUM Committee reviews and approves clinical practice guidelines, preventive health guidelines, and the disease management program.</p> <p>The disease management guides reflect educational outreach to members including mailings, telephonic outreach, access to community resources, and web-based education.</p> <p>The provider manual indicates that medical necessity determinations are made based on McKesson's InterQual® criteria, which is a nationally-recognized evidenced-based product. Copies of criteria used in making medical necessity determinations may be obtained online at www.directprovider.com, by phone or by requesting a hard copy. A Medical Director is available for peer-to-peer discussions.</p> <p>The Member Handbook discusses the UM program.</p>		<p>that approved clinical national guidelines such as InterQual are applied equitably throughout the MCO's provider network.</p> <p>UM evaluates medical necessity based upon evidence based medical guidelines and assures that providers are educated on current clinical criteria.</p> <p>With regard ensuring Inter-rater reliability, Report #23 indicates that the Health Services team has monitoring tools to measure the inter-rater reliability of clinical decision making for UM nurses and physicians.</p> <p>Further, the report states that inter-rater reliability testing was completed in Q4 2014 and would be reported to the QI Committee in Q1 or Q2 2015. The MCO added that the reporting schedule was currently under review.</p> <p>The November 2014 EQIC minutes have an agenda item related to IRR, however, there are no details provided and the results are not appended to</p>	Process to be developed for review of member education to ensure consistency with CPGs .



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>the minutes.</p> <p>The 2013 QI Evaluation references the UM Evaluation report which is available upon request.</p> <p>For provider practice, in the report, Performance Measurement of the Effectiveness of Disease Management and Adherence to Clinical Practice Guidelines and in the QM/UM meeting minutes that include reporting of the results to the committee.</p> <p>No documentation was found to address how member education materials are reviewed to ensure consistency with CPGs and no evidence that this had been done was provided.</p> <p>There was discussion of the Disease Management program and compliance with guidelines for asthma and diabetes in the report, Performance Measurement of the Effectiveness of Disease Management and Adherence to Clinical Practice Guidelines.</p>	
19.5 Innovative Programs				



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>Full-As per the QI Program Description, CCKY's Pharmacy Benefit Manager where applicable, uses a Drug Utilization Review (DUR) program, in conjunction with retail pharmacy computer systems, alerts pharmacies of potential drug to drug interactions and adverse effects resulting from the age or gender of a member; or other pharmacy problems at the time a prescription is filled.</p> <p>Additionally, CCKY maintains a local pharmacy and therapeutics (P&T) committee which is responsible for advising the National P & T Committees regarding local and community needs related to the health plan's pharmacy benefit program(s). The Kentucky P&T Committee is a sub-committee of the EQIC that ensures members receive the maximum value from their pharmacy benefit by continual reinforcement of high quality, cost-effective prescribing habits of CCKY practitioners.</p> <p>Meeting minutes indicate that the QMUM committee reviewed a Chronic Opiate Policy and the Fraud/Waste/Abuse report on Narcotics. A document entitled the "CoventryCares of Kentucky Prior Authorization for Schedule II, III and IV Opiate Containing Medications" was distributed by Medco, the plan's pharmacy vendor, to inform providers of changes to prior authorization requirements for short-acting and long-acting opiates.</p> <p>Regarding CCKY's program to improve and reform the pharmacy program, CCKY provided a spreadsheet containing monthly data for Suboxone versus generic dispensing. The rates dropped from 97.97% Suboxone/2.03% generic in April 2012 to 0.78% Suboxone/99.22% generic as of January 2013.</p>	<p>Full</p>	<p>Coventry's Innovative Programs and Status are as follows:</p> <p><u>Suboxone Innovation Program</u> An approval protocol for Suboxone. Requires the prescriber to evaluate the member's history of narcotic use based on medical history and online state Kasper report for the use of narcotics. Findings: Stemmed the use of based on Drug costs per member per month (Rx/PMPM).</p> <p><u>Narcotics Program</u> A protocol for patients with chronic pain using CII and CIII controlled substances. Requires the prescriber to evaluate the member's history of narcotic use based on medical history and online state Kasper report for the use of narcotics. Findings: A narcotic contract between the prescriber and member involving a limited duration of narcotic therapy based medical necessity and compliance with the medical treatment plan was key to improvement.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>During the onsite interview, CCKY indicated that this was achieved via use of co-pay tiers, formulary changes, and physician education and that in general, use of generics had increased to ~ 89 – 90%.</p> <p>In 2013, IPRO noted that reports on the plan's program to improve and reform the pharmacy program management were not provided for review. For the current review, CCKY provided more complete information, as described above.</p>			
20.1 Kentucky Outcomes Measures and HEDIS Measures				
<p>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 measures require</p>	<p>Full - In 2013, CCKY reported its first Healthy Kentuckians Outcomes performance measure rates. The QI Work Plan lists as objectives improving rates on the following indicators: BMI; Nutritional Screening/Counseling; Physical Activity Counseling; Height and Weight for children and adolescents; Cholesterol Screening for Adults; Adolescent Screening/Counseling; Prenatal Risk Assessment Counseling and Education; Children with Special Health Care Needs (CSHCN) (access and preventive care).</p> <p>In 2013, CCKY reported its first HEDIS measure rates. CCKY's HEDIS 2013 Results and Goals indicates that the following measures met the 10th percentile: Comprehensive Diabetes Care - Eye Exam; Controlling High Blood Pressure; Use of Imaging Studies for Low Back Pain; Weight Assessment Counseling – BMI, Nutrition, & Physical Activity; and Well Child Visits in the Third,</p>	Substantial	<p>Addressed in the 2014 QI Program Description, page 5 Objectives, G HEDIS. The HK measures are not specifically noted in the objectives, however, there is a statement regarding State public health goals. Also addressed in the 2014 QI Work Plan and the HEDIS/EPST/HK Work Plan.</p> <p>Evidenced in Report # 96 Coventry's 2014 reporting of Health Kentuckian (HK) Performance Measure rates and audited HEDIS rates for measurement year (MY) 2013 and Report #18 Monitoring Indicators, Benchmarks,</p>	<p>Coventry will evaluate our processes to seek to ensure that barrier analysis, based on data collection, is conducted and that a sufficient variety of active and targeted interventions are implemented for each PIP.</p> <p>Additionally, our Prevention and Wellness program being developed in 2015 will work to provide more active and targeted interventions.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>amended or different performance measures, the parties agree to amend the previously identified measures.</p>	<p>Fourth, Fifth, and Sixth Years of Life.</p> <p>The QI Evaluation relates that CCKY has posted gap reports to the provider portal (directprovider.com); worked collaboratively with MHNet on an initiative to address substance use in pregnancy; sent reminders for post partum visits; and addressed EPSDT services by hiring an EPSDT Case Manager, conducting outreach, sending reminders; working with high volume pediatric practices; and addressing members' transportation problems.</p>		<p>and Outcomes.</p> <p>Evidenced in the 2014 HEDIS/ EPSDT/HK Work Plan which details the interventions and activities related to the measures. As described in element</p> <p>In the 2013 QI Evaluation, Coventry addresses interventions targeting HEDIS and HK measures. However, many of the actions described are focused on availability of data and data collection. For instance, educating providers on HEDIS specifications, implementing HEDIS reporting, developing a supplemental database, and obtaining correct provider contact information for medical record retrieval. Many of the interventions targeting members are passive, e.g., mailed information, newsletters, and reminder cards.</p> <p>More active interventions related to some of the measures included: Collaborating with a large practice to produce gap reports/physician performance profiles, some telephone outreach, hiring a dedicated EPSDT</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Coordinator, direct outreach to members and providers for those with lead levels > 5, 17P program for women at risk for preterm delivery, Maternal Postpartum Program, crib incentive program, participation in community events and initiatives,</p> <p>Likewise, most of the provider-targeted initiatives were mailings.</p> <p>Also, the success rate for outreach, the number of members reached, was not documented so it is not clear if the outreach efforts were effective.</p> <p>The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.</p> <p><u>Recommendation for Coventry</u> Coventry should ensure that barrier analysis, based on data collection, is conducted and that a sufficient variety of active and targeted interventions are implemented for each PIP.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.	NA - CCKY reported its first HEDIS data in 2013. On annual basis DMS in collaboration with the EQRO, evaluates the measures required for reporting. The measure set has been revised and refined. MCOs are encouraged to provide input and have done so. To date, no measures have been rotated.	Not Applicable	To date, DMS has not chosen to rotate any measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	Full - The ISHCN measures were selected prior to CCKY's participation in Kentucky Medicaid. However, CCKY reported the Healthy Kentuckian Outcomes performance measures for the first time in 2013 as required.	Not Applicable	DMS, IPRO and participating MCO(s) developed a set of performance measures specific to ISHCN. Coventry reports the ISHCN performance measures annually via submission of rates and data to the EQRO, IPRO for performance measure validation.	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.	Full - CCKY reported the Healthy Kentuckian Outcomes performance measures for the first time in 2013 as required. Improvement initiatives are in progress. However, Remeasurement to assess improvement will not occur until 2014.	Not Applicable	To date, DMS has not chosen to set performance improvement thresholds for the performance measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO. Coventry reports the full performance	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			measures annually via submission of Report #96 and reporting the rates and data to the EQRO, IPRO for performance measure validation.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.	<p>Full - The Healthy Kentuckians Outcomes measures include performance targets/goals.</p> <p>The QI Program Description addresses both the Kentucky Appendix O measures and HEDIS measures.</p> <p>The QI Work Plan includes monitoring of indicator benchmarks and outcomes; quarterly reporting of QI initiatives; and lists each of the Appendix O performance measures as a task for improvement efforts.</p> <p>An annual report of performance measure data and demographic stratification will be reported in the 2013 QI Evaluation (pending committee approval). CCKY did submit its HEDIS data stratified with the final audit report and IDSS.</p>	Not Applicable	<p>To date, DMS has not chosen to set performance improvement thresholds for the performance measures.</p> <p>The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.</p> <p>Coventry reports the full set of performance measures annually via Report #96 and submission of rates and data to the EQRO, IPRO for performance measure validation</p> <p>Coventry submits Report #18 Monitoring Indicators, Benchmarks and Outcomes quarterly.</p>	
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's	Full - CCKY reported its first HEDIS data in 2013 and will report HEDIS 2014 in June 2104. The data was audited and CCKY provided the final audit report, IDSS, and stratified measure rates	Full	Includes review of MCO Report #96 Audited HEDIS Reports	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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 31 st .	as required.		Addressed in the 2014 QI Work Plan, which includes tasks for DMS reporting. Coventry submitted Report #96 Audited HEDIS Reports to DMS as required, including the HEDIS Final Audit Report and a report of rates from the Interactive Data Submission System (IDSS).	
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 - CCKY submitted the final audit report, IDSS, and table of HEDIS 2013 rates with percentile ranking and national average and 75 th percentile for comparison. No trending was possible, as this is the first reporting year. Denominators, numerators, and rates are included in the IDSS. A "HEDIS 2014" report was submitted and included CCKY's HEDIS 2013 results and goals for HEDIS 2014. According to CCKY, HEDIS 2014 goals were chosen using NCQA's HEDIS Benchmark and Goal Setting Methodology.	Full	Evidenced in the 2013 QI Evaluation, which provides the graphs of 2013 and 2014 performance compared to Quality Compass benchmarks. The HEDIS Interactive Data Submission System (IDSS), included in Report #96, contains the required data, including, but not limited to, denominators, numerators and rates. The reporting template for the HK Performance Measures includes columns for denominator, numerator, and rate for each measure.	
For all reportable Effectiveness of Care and Access/Availability of Care	Full - CCKY included the stratified Effectiveness of Care (EOC) and Access/Availability (A/A) measure rates in 2 embedded files	Substantial	Addressed in the 2014 QI Work Plan	Coventry will assess its current process for stratification to determine if



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	within the HEDIS report document submitted.		<p>Evidenced in Report #96 which contains an Excel file with the HEDIS data stratified by Medicaid eligibility category, race, ethnicity, gender and age.</p> <p>Note that only the numbers of compliant and non-compliant members for each sub-group are provided. The percentages are not provided. Numbers for some of the sub-groups are very small, so that limits the usefulness of the data.</p> <p><u>Recommendation for Coventry</u> Where feasible, Coventry should report the denominators, numerators and percentages for the sub-groups and compare the rates with the total population rates to assess for significant differences and disparities.</p>	percentages can be provided.
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The	<p>NA - HEDIS 2013 (Measurement Year 2012) was the first year for reporting at the CCKY.</p> <p>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.</p>	Not Applicable	<p>To date, DMS has chosen not to define a subset of measures for evaluation.</p> <p>The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.				
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 - HEDIS 2013 (Measurement Year 2012) was the first year for reporting by CCKY. To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	Not Applicable	To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.	
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,	NA - NCQA accreditation is planned for July 2014. Preparation for the accreditation survey is in progress as seen in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan.	Minimal	Coventry Cares earned NCQA accreditation with a status of "Accredited" for the period 8/21/2014-8/21/2017. Note that the accreditation was a "standards only" assessment. Coventry	Coventry explained during the EQRO audit of communication errors when delivering the result of the NCQA audit via email to DMS. Email trail was provided that showed difficulties on DMS side in opening the documents. DMS was finally able to open the



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>			<p>had only reported one year of data, HEDIS 2013 and CAHPS 2013 at the time of the survey so including the performance on those measures would not have been appropriate.</p> <p>Accreditation documents provided for the onsite review included only the NCQA cover letter and accreditation certificate.</p> <p>During the onsite review, Coventry provided a copy of an email regarding the accreditation documentation that was sent to DMS; however, the specific report components/attachments included were not discernible.</p> <p>DMS has a record of receiving only the accreditation certificate.</p> <p>Coventry needs to provide the following reports from the NCQA Interactive Survey System (ISS) to DMS with each accreditation cycle: A copy of the complete survey report that includes: The scoring at the category, Standard, and element levels</p>	<p>certificate. The final report was submitted to DMS and EQRO prior to the EQRO on site audit being concluded.</p> <p>HEDIS and CAHPS review was not included in this NCQA audit.</p> <p>Coventry will provide the documentation listed for each accreditation survey and any interim updates.</p> <p>At the next accreditation review in 2017, Coventry will include both standards and HEDIS/CAHPS performance review.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Status Summarized & Detailed Results Performance Performance Measures Must Pass Results NCQA Recommendations History.</p> <p><u>Recommendation for Coventry</u> Coventry should provide the documentation listed above to DMS as soon as possible and thereafter, for each accreditation survey and any interim updates.</p> <p>At the next accreditation review in 2017, Coventry should include both standards and HEDIS/CAHPS performance review.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>DMS confirmed that the accreditation report was not received in the review year, CY 2014. It was received in 3/2015, during the onsite review.</p> <p>The MCO needs to provide the</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>accreditation documentation, as required by the contract, when the accreditation results are received. A copy of the complete survey report with all applicable elements.</p> <p>Upon the next review, IPRO will review the accreditation documentation submitted to DMS to ensure same.</p>	
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.	NA - CCKY is currently pursuing accreditation.	Full	Coventry Cares earned NCQA accreditation with a status of "Accredited" for the period 8/21/2014-8/21/2017.	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the	<p>Full - The 2013 PIPs address topics that are issues of state and national concern and areas where CCKY did not meet national benchmarks: Major Depression and ED Utilization.</p> <p>The 2014 PIP topics include Preventing Readmissions and ADHD.</p> <p>CCKY's PIP proposals included strong rationales, with current</p>	Full	<p>Includes review of MCO Reports: #19 PIPs #90 PIP Proposal #92 PIP Measurement</p> <p>Addressed in Policy and Procedure QI-005 Performance Improvement</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>performance, relevance to the plan membership, potential disparities.</p> <p>The PIP topics were approved by the EQIC and the QM/UM committees, and ultimately, by DMS and the EQRO, IPRO.</p>		<p>Projects, this outlines the process, including types of projects (clinical and non-clinical), prioritizing topics to address the needs of members, interventions, and monitoring status.</p> <p>Evidenced in Report #90, Report #92, and Report #19. Coventry PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions and (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes.</p> <p>PIP topics include one BH and one PH annually, as required. Each of the PIP topics was approved by DMS. The 2015 Use of Antipsychotics PIP is a statewide collaborative directed by DMS.</p> <p>The PIP topics were approved by the EQIC and the QM/UM committees, and then by DMS and the EQRO, IPRO as evidenced in the PIP attestations.</p> <p>Coventry's PIP proposals include appropriate rationales supported by MCO historical performance, relevance</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			to the MCO's membership, and relevant state, national and Medicaid-specific data.	
<p>The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a <i>Member</i>. 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</p>	<p>Full - P/P QI-005 outlines the process for PIPs, including types of projects (clinical and non-clinical), prioritizing topics to address specific needs of members and subsequent to population analysis, interventions, and monitoring status was provided onsite.</p> <p>The PIP topics were based on some monitoring of plan performance with regard to antidepressant adherence, ED utilization, care for ADHD and rates of hospital readmissions. The PIPs each address clinical topics, with one for PH and one for BH for each year, as required. The PIP topics were approved by DMS and the EQRO, IPRO.</p> <p>No non-clinical/service PIPs have been proposed, though CCKY has addressed service improvements for internal purposes.</p> <p>To date, no additional PIPs have been required of CCKY by DMS. However, CCKY has participated in EQRO focus studies related to postpartum and newborn readmissions and EPSDT services.</p>	Full	<p>Addressed in Policy and Procedure QI-005 Performance Improvement Projects, this outlines the process, including types of projects (clinical and non-clinical), prioritizing topics to address the needs of members, interventions, and monitoring status.</p> <p>Evidenced in Report #92 for the following PIPs, which includes baseline and interim results: 2013 Major Depression: interim 2013 Emergency Room Utilization: interim 2014 Reducing Readmissions: baseline 2014 ADHD: baseline (submitted late)</p> <p>Coventry also submits quarterly updates on its PIPs, Report #19.</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.				
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.	<p>Full - Collaborative relationships are addressed in P/P QI-005, which was provided onsite. During the onsite interviews, CCKY described collaboration with local Departments of Public Health noting that it works with 196 LHDs in the 120 counties it serves, via local outreach staff.</p> <p>Initiatives include: substance abuse in pregnancy; community events such as baby showers and diabetes education; biweekly meetings to collaborate on provider relations and coverage issues.</p> <p>CCKY worked to address LHD concerns regarding Norton Health System participation in its network.</p>	Substantial	<p>Addressed in Policy and Procedure QI-005 Performance Improvement Projects.</p> <p>The QI Program Description states that the health plan collaborates with participating providers and other relevant entities when necessary to meet program needs. It does not address collaborating with local health departments, behavioral health agencies and other community-based health/social agencies.</p> <p>Coventry collaborates with local Departments of Public Health in the</p>	<p>Coventry is developing its Prevention and Wellness program for 2015 and will be inclusive of targeting partnerships with local health departments, behavioral health agencies and other community based health/social agencies.</p> <p>This collaboration will be updated in the PIPs as the objectives and activities are defined and implemented.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>120 counties it serves via local outreach staff.</p> <p>Coventry is participating in the statewide collaborative with DMS, the other MCOs, and University of Louisville.</p> <p>The PIP reports and updates demonstrate collaboration across the organization and with MHNet; working with providers is primarily via educational initiatives, and there is some collaboration with hospital EDs however collaboration with outside entities, such as local health departments, behavioral health agencies and other community based health/social agencies was not seen.</p> <p>Coventry does work with community agencies via the QMAC and participates in community events</p> <p><u>Recommendation for Coventry</u> Coventry should integrate collaboration with local health departments, behavioral health agencies and other community based</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			health/social agencies in the PIP Interventions.	
The Contractor shall be committed to ongoing collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data-driven performance measures.	<p>Full - The QI Program Description states that CCKY will cooperate with DMS and the EQRO on improvements in services and clinical care concerns.</p> <p>CCKY has participated in EQRO focused studies and fulfilled QI contract requirements, including conducting PIPs, reporting performance measures and HEDIS, participating in EQRO focused studies, and submitting documentation and data for the annual review.</p>	Substantial	<p>The QI Program Description states that the MCO will cooperate with DMS and the EQRO on improvements in services and clinical care concern and notes a commitment to quality and industry best practices. Use of encounter data-driven performance measures is not addressed.</p> <p>Evidenced in Coventry's participation in EQRO focused studies, encounter data validation, conducting PIPs, reporting HEDIS and HK Performance Measures, and submitting documentation and data when requested by DMS and/or the EQRO, IPRO.</p> <p>Encounter data is not sufficiently complete and accurate at this time; therefore, DMS and the MCOs cannot use the data for performance measure calculation. The EQRO is conducting encounter data validation and benchmarking studies to assess and improve data quality.</p>	Encounter data-driven performance measures will be added to the QI Program Description.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for Coventry</u> Coventry should add the use of encounter data-driven performance measures to its QI Program Description.</p>	
<p>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 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</p>	<p>Full - As described previously, CCKY has two 2013 PIPs in progress and submitted proposals for two 2014 PIPs. The PIPs address behavioral health and physical health needs. PIP reports have been submitted as required.</p> <p>CCKY has not submitted an alternate PIP topic. DMS has not required CCKY to implement an additional PIP.</p> <p>DMS has not yet required CCKY to participate in a state-wide PIP, but MCOs have assisted with EQRO focused studies by providing requested data and documentation.</p>	<p>Substantial</p>	<p>Addressed in Policy and Procedure QI-005 Performance Improvement Projects.</p> <p>In 2014, Coventry has submitted PIP reports, including two PIP proposals, 2 baseline reports and 2 interim measurement reports as evidenced in Report #90 and Report #92.</p> <p>In 2014, one baseline report was submitted late (ADHD PIP) and one revised proposal was submitted late (Antipsychotic Use PIP).</p> <p>The PIPs include on behavioral health and one physical health topic for each year.</p> <p>The 2015 Use of Antipsychotics for Children and Adolescents is the first</p>	<p>All reports will be submitted in a timely manner according to the due dates outlined in the contract.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.			statewide collaborative PIP. Coventry is participating in the collaborative and submitted a PIP proposal. DMS has not directed Coventry to conduct an additional PIP. <u>Recommendation for Coventry</u> Coventry should ensure that all PIP reports are submitted timely.	
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 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	Full - CCKY initially proposed topics for each of the four areas identified by DMS. After clarification, CCKY submitted two proposals for 2013 PIPs: Major Depression and ED Utilization. These topics were approved by DMS. CCKY also submitted proposals for two 2014 PIPs: Hospital Readmissions and ADHD. Those topics were approved by DMS as well.	Full	Addressed in Policy and Procedure QI-005 Performance Improvement Projects. The project topics for both physical and behavioral health were directed or approved by DMS. Coventry's PIP topics were approved by DMS and the EQRO as seen in the signed Attestation for each PIP.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Other Regions contract				
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 - CCKY submitted the PIP proposals on the template specified by DMS. The proposal topics were approved. P/P QI -005 addresses the elements below and was provided onsite.	Full	Evidenced in Report #90 and Report #92 for the PIP in progress. Coventry used the required templates for its proposals, baseline reports and interim reports.	
A. Topic and its importance to enrolled members;	Full - Topic relevance was well described in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	Substantial	Topic relevance was well supported and appropriate for five of the six PIP proposals. IPRO recommendations related to PIP rationale are listed below. Coventry did not address the recommendation. ADHD: The health condition is described, but not the intended means for improvement by "Offering enhanced and comprehensive services to children with ADHD". As mentioned in the 2013/2014 proposal comments (dated 1/8/2014), the topic should clearly be specified by including both the health condition and the focus on improving treatment for this condition. <u>Recommendation for Coventry</u>	Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting. The topic will be clearly specified by including both the health condition and the focus on improving treatment for this condition. The MCO has submitted a CAP related to its PIPs to DMS.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Coventry should ensure that all PIP recommendations are addressed or resolved.</p> <p>The MCO has submitted a CAP DMS related to its PIPs to DMS.</p>	
B. Methodology for topic selection;	Full - Rationale for the topic selection included statewide and plan-specific data to justify topic selection for each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	Substantial	<p>The rationale for each of the PIPs included national, statewide and plan-specific data to justify topic selection.</p> <p>IPRO recommendations related to PIP rationale are listed below. Coventry did not address the recommendation.</p> <p>ADHD PIP: The rationale does not present coherent and consistent performance improvement topic and performance measures in accordance with the recommendations made in the proposal review, dated 1/8/2014.</p> <p>Recommendation for Coventry Coventry should ensure that all PIP recommendations are fully addressed or resolved.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS.</p>	<p>Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.</p> <p>Rationale will be more clearly defined in all future reporting.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
C. Goals;	Full - Goals/targets for improvement are included in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	Minimal	<p>Goals/targets for improvement are included in each of the PIP proposals.</p> <p>IPRO recommendations are listed below.</p> <p>Diabetes Care: Clarify whether the goal is to improve 4% from baseline or 4 percentage points from the baseline rate.</p> <p>Preventing Readmissions: The targeted improvement is stated as a 2 percentage point improvement. The Plan needs to provide a specific rationale for this goal.</p> <p>ADHD PIP: CoventryCares should quantify goals for each indicator based upon improving past performance and or achieving established benchmarks.</p> <p>This requirement scored Minimal due to the deficiencies related to PIP goals and the MCO did not address the PIP recommendations.</p> <p><u>Recommendation for Coventry</u></p>	<p>Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.</p> <p>Goals and/or targeted improvement will be more clearly defined in all future reporting.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Coventry should provide goals with appropriate rationale for each PIP/indicator.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS.</p>	
D. Data sources/collection;	Full - Data sources and collection procedures were described in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	Minimal	<p>Data sources and collection procedures were described in each of the four PIP proposals.</p> <p>The IPRO evaluation and comments regarding indicators and methodology are described below.</p> <p>Preventing Readmissions: critical recommendations were not addressed.</p> <p>ADHD: critical recommendations were not addressed.</p> <p>Depression: Indicators and methodology were scored partially met.</p> <p>ED Utilization: Indicators and methodology were scored partially met.</p>	<p>Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.</p> <p>Critical recommendations, indicators and methodology will be addressed and included in all future reporting.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>This requirement scored Minimal because the MCO did not address the PIP recommendations.</p> <p><u>Recommendation for Coventry:</u> Coventry should review the prior PIP recommendations and address or resolve them.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS.</p>	
<p>E. Intervention(s) – not required for projects to establish baseline; and</p>	<p>Full - Active and targeted interventions were described in each of the four PIP proposals though there were relatively passive interventions in some cases. CCKY revised the proposals based on EQRO recommendations.</p>	<p>Minimal</p>	<p>Interventions were described in the PIP proposals and reports.</p> <p>The IPRO evaluation and comments regarding indicators and methodology are described below. Diabetes: There were a variety of recommendations on barrier analysis and interventions. These were not fully addressed.</p> <p>Preventing Readmissions: There were a variety of recommendations on barrier analysis and interventions. These were not fully addressed.</p>	<p>Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.</p> <p>Barrier analysis and interventions will be addressed and included in all future reporting.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>ADHD: There were a variety of recommendations on barrier analysis and interventions. These were not fully addressed.</p> <p>Depression: Interventions were scored partially met.</p> <p>ED Utilization: Interventions were scored partially met.</p> <p>This element scored minimal because the MCO did not fully address the PIP recommendations.</p> <p><u>Recommendation for Coventry:</u> Coventry should review the PIP recommendations and addressed them where necessary.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS.</p>	
<p>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.</p>	<p>Substantial - Baseline results for the 2013 PIPs were submitted, but in some cases, were not clear, requiring clarification. CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports.</p>	<p>Minimal</p>	<p>Baseline results were reported for two PIPs and interim results were reported for two PIPs.</p> <p>The IPRO evaluation and comments</p>	<p>Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs.</p> <p>Recommendation for CCKY Baseline results should be clearly presented in the PIP reports.</p> <p>MCO Response: CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports.</p> <p>A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs.</p> <p>Baseline measurements completed for reports in 2014 will follow the recommendations for clearly comparing results to our goals.</p>		<p>regarding results reported are described below.</p> <p>Preventing Readmissions: The Results section should not include narrative related to other parts of the PIP. The MCO should modify the table in Appendix A for this specific PIP and put the table in the Results section. The Results section should include a table with eligible population(s), denominator(s), numerator(s), rate(s) and goal(s) with the performance indicator name(s) and measurement timeframe defined in the title and column headings. The proposal described stratifying the performance indicator results; no stratification of the measures is presented. In the Results section, the MCO reported on contacts to members who had been discharged. This process measure needs to be linked to a specific intervention and reported in a table for process measures in the Results section.</p> <p>ADHD: No baseline results were provided. Only with results of process</p>	<p>Baseline results, tables, narrative and formatting will be updated to meet EQRO recommendations.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>measures for mailings are provided. The results for MY 2013/RV 2014 should be reported. If Coventry adopts the indicators suggested by IPRO, data for MY 2013 can be reported. The MCO should provide a table with the indicator(s) and the baseline eligible population(s), denominator(s), numerator(s), baseline rate(s) and benchmark rate(s) for each indicator. The process measures should include some measure of effectiveness of the interventions.</p> <p>Depression: Presentation of results clearly was scored not met. Comments and recommendations related to lack of clarity in the format used for reporting and the results presented; baseline data was not reported in the Results section; data for the final measurement should not be reported in the interim report; the benchmark needs to be clarified; clarifying the goal for the MPR measure; presentation of results as percentages; the figures need to be revised (data to be included, e.g., denominators); wording to use when reporting on</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>improvement; interpretation of results; and suggestions on how to drill down into the data to inform interventions.</p> <p>ED Utilization: Presentation of results clearly was scored not met. Comments and recommendations related to lack of clarity in the format used for reporting and the results presented and were very similar to the comments for the Depression PIP.</p> <p><u>Recommendation for Coventry</u> Coventry should address the PIP recommendations.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS.</p>	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Full - The four PIP proposals address member confidentiality.	Not Applicable	No final remeasurement reports are due; however, all PIPs address member confidentiality.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
B. Did Members participate in the performance improvement project;	NA - PIPs are still in process; however, member interventions are addressed in all PIPs.	Not Applicable	No final remeasurement reports are due; however, member interventions are addressed in all PIPs.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	NA - PIPs are not yet completed.	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 - PIPs are not yet completed.	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 - PIPs are not yet completed.	Not Applicable	No final remeasurement reports are due; therefore, it is not possible for Coventry to provide an Executive Summary.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	Substantial - As indicated previously, the baseline results for the 2013 PIPs were sometimes not clear, requiring clarification. CCKY followed the EQRO recommendations and was able to more clearly present the results. <u>Recommendation for CCKY</u> Baseline results should be clearly presented in the PIP reports.	Not Applicable	No final remeasurement reports are due; however, presentation of results for baseline and interim measurements is discussed under element 20.4 Performance Improvement Projects, The Contractor...must address all of the following in order for the Department	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>MCO Response: CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports.</p> <p>A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs. Baseline measurements completed for reports in 2014 will follow the recommendations for clearly comparing results to our goals.</p>		to evaluate the reliability and validity of the data and the conclusions drawn, requirement F.	
<p>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</p>	<p>Substantial - CCKY used HEDIS measures for indicators where available and also selected Medication Possession Ratio for the MDD PIP. However, in some cases, CCKY's methodology for use of the measures was not clear. CCKY was able to clarify the indicators with EQRO assistance.</p> <p>For HEDIS measures, the goals were based on benchmarks from national data.</p> <p>Recommendation for CCKY PIP methodology should be clearly presented in the PIP reports.</p> <p>MCO Response: CCKY followed the EQRO recommendations and was able to more clearly define the methodology. PIP methodology for reports in 2014 will follow the recommendations for clear presentation.</p>	Minimal	<p>The IPRO evaluation and comments regarding indicators and methodology are described below.</p> <p>Preventing Readmissions: critical recommendations were not addressed.</p> <p>ADHD: critical recommendations were not addressed.</p> <p>Depression: Indicators and methodology were scored partially met.</p> <p>ED Utilization: Indicators and methodology were scored partially met.</p> <p>The IPRO evaluation and comments regarding performance goals are described below:</p>	<p>Coventry will review the prior recommendations and address them as agreed upon with DMS/IPRO (CAP) in all future reporting.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS</p>



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Diabetes Care: Clarify whether the goal is to improve 4% from baseline or 4 percentage points from the baseline rate.</p> <p>Preventing Readmissions: The targeted improvement is stated as a 2 percentage point improvement. The Plan needs to provide a specific rationale for this goal.</p> <p>ADHD PIP: CoventryCares should quantify goals for each indicator based upon improving past performance and or achieving established benchmarks.</p> <p>Recommendation for Coventry: Coventry should review the prior recommendations and addressed them where necessary.</p> <p>The MCO has submitted a CAP related to its PIPs to DMS.</p>	
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and	NA - The 2013 PIPs are in the baseline/interim phase and the 2014 PIPs are in the proposal stage.	Not Applicable	No final remeasurement reports are due; therefore, sustained improvement cannot be evaluated.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
maintenance of the interventions that resulted in improvement. The timeframes for reporting:				
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 - The initial 2013 and 2014 PIP proposals were submitted on or before September 1 st of the respective year (2012 or 2013).	Minimal	Coventry submitted its project proposals timely. Revisions to one proposal were submitted late (Antipsychotic Use PIP – due 12/20/15, received 12/30/15). Recommendation for Coventry Coventry should ensure that revised proposals are submitted timely.	All revised proposals will be submitted timely based on the timeline outlined by DMS and/or IPRO.
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 - The 2013 PIP baseline reports were submitted August 31, 2013.	Minimal	Coventry submitted one baseline report late in 2014 (ADHD PIP – due 9/1/14, received 9/18/14). Recommendation for Coventry Coventry should ensure that all PIP reports are submitted timely.	All reports will be submitted in a timely manner according to the due dates outlined in the contract.
C. 1 st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	NA - The 2013 PIPs are currently in the first year. The 2014 PIPs are in the proposal/baseline measurement phase.	Full	Coventry submitted the interim reports timely.	
D. 2 nd Remeasurement – no more than	NA - The 2013 PIPs are currently in the first year. The 2014 PIPs	Not Applicable	No final remeasurement reports are	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
one calendar year after the first remeasurement and no later than September 1 of the contract year.	are in the proposal/baseline measurement phase.		due.	
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 - The plan has established a Quality and Member Access Committee as a subcommittee of the EQIC. The committee's membership includes members and consumer advocates. There are regional quarterly meetings of the QMAC. The plan submitted QMAC meeting minutes. Membership lists reveal a variety of community interests represented.	Minimal	Includes review of MCO Report #21 MCO Committee Activity The QMAC is not addressed in the 2014 QI Program Description with the other committee descriptions. Report #21 states that there are four regional groups: South-West (Regions 1, 2 & 4), North Central (Region 31), North East (Regions 5 & 6), and East (Regions 7 & 8) and the purpose of the committee is to interact with members and get their feedback on topics such as quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the Plan. Report #21 for Q1 – Q4 2014 demonstrates that there were 6 QMAC Meetings during 2014. Coventry held QMAC meetings in several venues each	QMAC has been added as a regular committee in the 2015 QI Program Description, including the members, roles, responsibilities and meeting frequency. Documentation of member recruitment efforts will be maintained and discussed during the committee update at the QMOC meetings.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>quarter. In Q1, there were 4 meetings in Region 31, Regions 1 & 2, Regions 5 & 6 and Regions 7 & 8. In Q2 there was 1 meeting in Region 31. In Q3 there was 1 meeting comprised of Regions 1, 2, & 4. In Q4, no meetings were held.</p> <p>The content of the meetings was not consistent and in some cases, was very limited.</p> <p>There did not appear to be a standing committee membership, rather, varied members and advocates and community groups attended.</p> <p><u>Recommendation for Coventry</u> Coventry should include the QMAC as a regular committee in its QI Program Description, including the members, roles, responsibilities and meeting frequency.</p> <p>The QMAC responsibilities should include review of the QI Program Description, QI Work Plan, QI Evaluation, member materials and all materials required by the contract.</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

**Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)**

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The QMAC should have a standing membership comprised of community advocates and members for consistency. Others can be invited to participate as guests.	
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 - Consistent with the Committee Description, the quarterly reports indicate that the QMAC sub-committee meets quarterly and the committee is comprised of members and consumer advocates who represent the interests of members. The QMAC meetings are held in four regional groups: South-West (Regions 1, 2 & 4), North Central (Region 31), North East (Regions 5 & 6), and East (Regions 7 & 8) so that members from across the state are represented.	Full	Report #21 indicates that the QMAC meets quarterly and the committee is comprised of members and consumer advocates who represent the interests of members. <u>Recommendation for Coventry</u> Coventry should document in the minutes the specific title/role of each member in attendance. For example, MCO member, community advocate with the organization represented/role of the attendee.	
A. Providing review and comment on quality and access standards;	Full - According to the Committee Description, the purpose of the committee is to interact with members and get feedback on quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the plan. QMAC meeting minutes include discussion and review of the QI Program Description and the QI Work Plan and review of the	Minimal	Report #21, including QMAC meeting minutes demonstrated that primarily, the committee members are provided with information about Coventry and its various programs (Lock-In, HEDIS, PIPs). The QI Program Description, QI Work Plan and QI Evaluation were not presented to the committee for review	This has been added as a standing agenda item for 2015 and moving forward.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	Provider Directory, overview of QI, HEDIS measures and EPSDT standards.		and comment. In general, there were a few questions and comments from the committee members. <u>Recommendation for Coventry</u> Coventry should ensure that the QMAC fulfills its purpose and feedback and input from the committee members is obtained.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Full - The quarterly report 131030 contains QMAC minutes discussing the Appeals and Quality of Care Grievances processes. During the onsite interview, CCKY indicated that during the first committee year (2012) the QMAC was a statewide committee that involved too much travel for participants. CCKY changed to the regional model as described above. There are outreach coordinators in the four regions who recruit members and advocates including CSHCN advocates and coordinate meetings and communication. In Q4 2013, the QMAC reviewed the Member Handbook and member educational materials.	Minimal	The QMAC meeting minutes do not provide evidence of review and comment on the Grievance and Appeals process or aggregated data on grievances and appeals in 2014. <u>Recommendation for Coventry</u> Coventry should ensure that the QMAC fulfills its purpose and responsibilities as required by the contract.	<u>DMS Response</u> This element also scored Minimal in 2013 and DMS has concerns. <u>Coventry Response</u> This has been added as a standing agenda item for 2015 and moving forward.
C. Providing review and comment on Member Handbooks;	Full - The QMAC bi-annual report to EQIC includes evidence of QMAC review and comment on the Member Handbook.	Non-Compliance	The QMAC meeting minutes do not provide evidence of review of the Member Hand book.	This has been added as a standing agenda item for 2015 and moving forward.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
D. Reviewing Member education materials prepared by the Contractor;	Full - Quarterly report 130430 includes QMAC review of the Member Handbook, member educational materials, the Provider Directory, and the CCKY website.	Non-Compliance	The QMAC meeting minutes do not provide evidence of review of Member education materials.	This has been added as a standing agenda item for 2015 and moving forward.
E. Recommending community outreach activities; and	Full - Quarterly reports describe QMAC review of CCKY's community outreach activities such as the Baby Crib Program, Teen Mom Program and Smoking Cessation Program. The meeting minutes indicate that community advocates who were present at the meeting were encouraged to share their upcoming events.	Full	The QMAC meeting minutes include evidence of discussion of community outreach activities.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - QMAC minutes reveal review of EPSDT and lead screening programs, the Quality of Care process, review of PIPs and member handbook, provider directory and formulary. As noted previously, the QMAC reviewed the P/P for grievances and appeals.	Full	The QMAC meeting minutes show that the committee reviewed policies that affect Members, such as co-pays, benefits, and enrollment.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - CCKY submitted a list of QMAC members in the Q1 2014 Quarterly Report (reporting period 10/2013 – 12/2013). The member list reveals a variety of community interests represented.	Substantial	The list of members is provided in Report #21. Based on the meeting minutes, there did not appear to be a standing committee membership, rather, varied members and advocates and community groups attended. <u>Recommendation for Coventry</u> The QMAC should have a standing membership comprised of community	QMAC has been added as a regular committee in the 2015 QI Program Description, including the members, roles, responsibilities and meeting frequency. Documentation of member recruitment efforts will be maintained and discussed during the committee update at the QMOC meetings.



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			advocates and members for consistency. Others can be invited to participate as guests.	
20.9 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full - The plan conducted the CAHPS survey in 2013 and the Provider Satisfaction Survey in 2012 and 2013.	Full	Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys Coventry conducted CAHPS Surveys for the Adult, Child and CHIP populations in 2014. Report #22 indicates that the Provider Satisfaction Survey was completed in May 2014. The Survey was disseminated via Fax Blasts and in messages with provider remittance notices. There was an extremely low response rate; therefore, the MCO explored the use of an outside vendor to conduct the survey in Q3 2014. The MCO used a vendor to field a new Provider Satisfaction Survey in Q4 2014. The survey was fielded via telephone with 425 surveys	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			completed. The results were to be presented to the QMOC in February 2015 and interventions will be developed to address the findings.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - The QI Work Plan includes administration and analysis of the CAHPS survey. The QI Work Plan indicates that the results were reported to SAC committee in September 2013. DSS is CCKY's survey vendor. The survey was submitted to DMS.	Full	The 2014 QI Work Plan indicates that the CAHPS report to the Department in August 2014. Report #22 and Report #94 for Q3 2014 document submission to DMS.	
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 - CCKY reported that CM Satisfaction surveys are administered and that a POS type Customer Service Survey for both members and providers is being considered. The EQRO, IPRO, will be conducting a BH-focused survey.	Full	The 2014 QI Work Plan indicates that surveys were conducted for member satisfaction with chronic case management (CCM) and disease management (DM) programs. Report #22 for Q1- Q4 2014 includes the monthly CCM survey results. Report #22 for Q2 2014 describes a Member Understanding Survey which is administered monthly to new enrollees to assess understanding of benefits and MCO processes. According to Report #22, the member	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>satisfaction surveys for Disease Management (DM) and Neonatal Intensive Care Program and High Risk Obstetrics are conducted annually and were planned for Q4 2014.</p> <p>According to Report #22 for Q4 2014, the DM survey is fielded by the corporate branch and had not been sent as of 12/31/14.</p>	
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.	<p>Full - As per the Work Plan, the 2013 Provider Satisfaction Survey was scheduled in the third quarter.</p> <p>The tool and report were submitted to DMS.</p>	Full	The 2014 QI Work Plan and Report #22 indicate that the Provider Satisfaction Survey was completed in December 2014 and the report was to be presented to the QMOC in February 2015.	
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	<p>Full - The plan provided a copy of the Provider Satisfaction Survey report and the CAHPS survey results; these reports included methodology, response rates, and survey items.</p>	Full	Coventry submitted Report #22 quarterly and Report #94 CAHPS to DMS as required.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.			The 2013 QI Evaluation contains the 2013 Provider Satisfaction Survey results. These report included methodology, response rates, and survey items.	
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - CCKY submitted the Provider Satisfaction Survey report and included this in the pre-site documentation.	Full	Coventry submitted Report #22 quarterly and Report #94 CAHPS to DMS as required. The 2013 QI Evaluation contains the 2013 Provider Satisfaction Survey results. The report included the methodology, response rates, and survey item results.	
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.	Full - The QI Program Description reports that the plan will make available to state Medicaid agencies as contractually required and upon request all data, clinical and other records/reports for review of quality of care, access and utilization issues including, but not limited to, activities related to External Quality Review (EQR), HEDIS [®] , encounter data validation, and other related activities. CCKY submits Quarterly Status Reports to DMS are required.	Full	Addressed in the 2014 QI Program Description, which states that the MCO will make available to state Medicaid agencies as contractually required and upon request all data, clinical and other records/reports for review of quality of care, access and utilization issues including, but not limited to, activities related to External Quality Review (EQR), HEDIS, encounter data validation, and other related activities.	



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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Evidenced in Coventry's submission of the 2014 QI Work Plan and quarterly updates, Report #17.	



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

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	58	12	20	2
Total Points	174	24	20	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		2.37		

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



KY EQRO ANNUAL REVIEW

March 2015

Period of Review: January 1, 2014 – December 31, 2014

MCO: CoventryCares of Kentucky

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 services



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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				
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-2013			
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)	Substantial - Provider Manual; Section 10 Complaint Process for Provider and Members describes the process for a provider to file an appeal on the member's behalf however, but does not include that a provider may file a grievance on a member's behalf or the process . P/P APP-002, 003, 004, 006, indicate that a grievance may be filed either orally or in writing within 30 days of the event, and that a member, representative or service provider have the right to file a grievance on behalf of the member. Recommendation for CCKY As noted in the prior review, CCKY should include the process for filing a grievance on a member's behalf in the Provider Manual. MCO Response: CoventryCares of	Minimal	Addressed in APP-004 Member Grievance, page 3 and APP-003 Appeals and Grievances. Communicated to members in the Member Handbook on page 55 (version 1, 2014) and page 57 (version 2, 2014). Provider appeals and grievances are addressed in both the 2013-2014 and the 2015 Provider Manuals, Section 10. Communication to providers of the process for filing a grievance on behalf of a member was not addressed in either the 2013-2014 nor the 2015 Provider Manual, Section 10. Complaint Process for Providers and Members, B. Member Grievance and Appeals Process, The 2014 Provider Manual was not found in the documents submitted but was located on the MCO website.	MCO Response Will add statement to Provider Manual as found in the Member Handbook 2013-14 version "your provider can also file a grievance with your written permission." In the 2016 version.



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	Kentucky will updated the Provider Manual to include the process for filing a grievance on a member's behalf in the Fall 2014 Provider Manual.		<p><u>Recommendation for CoventryCares</u> CoventryCares should update the Provider Manual to include the process for a provider to file a grievance on behalf of a member.</p> <p>This element is scored Minimal because the MCO did not address the same recommendation for the prior two reviews.</p>	
24.1 Grievance and Appeal Policies and Procedures				
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-2013			
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	Substantial - Addressed in P/P APP-002, 003, 004, and 006. Provider Manual, Section 10 Complaint	Non-Compliance	Addressed in APP-002 Appeals – Members for appeals and APP-004 Member Grievance.	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p> <p>KAR 17:010 Section 4 (2), (4) (a) and Section 15 (1)</p>	<p>Process for Provider and Members describes the process for a provider to file an appeal on the member's behalf with a signed consent but does not address that a provider may file a grievance on a member's behalf, the process, or the need for consent.</p> <p>In the prior review, IPRO recommended that the requirement for written member consent for a provider to file a grievance on behalf of a member be included in the Provider Manual.</p> <p>This requirement was added to P/Ps but not to the respective handbook/manual for communication to members and providers.</p> <p><u>Recommendation for CCKY</u> CCKY should ensure that providers' filing grievances on behalf of members with consent is communicated to both members and providers by including this in the respective handbook/manual.</p> <p>MCO Response: CoventryCares of</p>		<p>Communicated to members in the Member Handbook, pages 55-60 (version 1, 2014) and pages 57-62 (version 2, 2014).</p> <p>The 2013-2014 and the 2015 Provider Manuals, Section 10, Complaint Process for Provider and Members, pages 105-110, describes the process for a provider to file an appeal on the member's behalf with a signed consent but neither addresses that a provider may file a grievance on a member's behalf, the process, or the need for consent.</p> <p>This element is scored Non-Compliance because the MCO did not address the same recommendation for the prior two reviews.</p>	



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	Kentucky will update the Provider Manual to include the requirement for written member consent for a provider to file a grievance on behalf of a member. This will be updated in the Fall 2014 Provider Manual.			
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 representative of a deceased Member as parties to the appeal. KAR 17:010 Section 4 (4) (a), (5) , (6), and Section 15 (1)	Full-2013			
A. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	New Requirement	Minimal	CoventryCares submits Report #29 Grievances and Appeals Narrative to DMS each quarter. The report describes the patterns in grievances and appeals for members and providers. For member and provider grievances, the	<u>MCO Response</u> CoventryCares of KY will include more specific data and information in future reporting.



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>report identifies categories of grievances which represent trends and opportunities for improvement.</p> <p>The report only presents the categories of grievances, e.g., access, claims payment, quality of care. The report does not contain data supporting the narrative (e.g., percentage of member grievances related to access versus other categories). The report does not identify the specific issue(s) that contribute to the trends/opportunities or specific actions. For example, percentage of complaints related to access to participating dental providers in a region, long appointment wait times in a region. For providers, claims processing issues related to use of a specific modifier.</p> <p>The report does not provide specific actions to be taken. For example, related to member access to care: the report indicates that CoventryCares continues to recruit providers, build relationships with the network and assist with provider education. More specific actions based on analyses such as those noted above would be expected. For provider claim issues, general and targeted educational efforts</p>	



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

Final Findings

Grievance System (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>related to the specific claims issues for MCO staff or providers, as needed. Additionally, specific impact on policies, procedures, access and utilization are not provided. There is a very general comment regarding CoventryCare's review of member/provider complaints/grievances to identify and address opportunities.</p> <p><u>Recommendation for CoventryCares</u> The MCO should perform and report more detailed analyses on grievances and appeals and identify the specific contributing factors as well as indicate the actions to be taken for the opportunities identified.</p>	
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	Substantial	As described in Aetna Medicaid Records Retention and Destruction Procedure, 4. Department-Specific Retention, Labeling and Storage, Record Series Code: INS 30-10-02, Record Series Subject: Complaints, Grievances and Appeals – Medicaid, Record Series Description: Records documenting complaints, grievances, and appeals from insured, members, providers or government agencies...including correspondence, supporting documents and resolution. Storage Medium and Location: Electronic Storage PHX Shared	<p>MCO response: CoventryCares of KY currently houses all Appeals and Grievances in the database.</p> <p>Not sure if this will change with Aetna</p>



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
			<p>Drive; offsite. The wording of the policy appears to indicate that the grievances and all related documents are stored together.</p> <p>During the onsite review, CoventryCares provided screen prints of the appeals and grievances systems to show that documents cannot be accessed from the appeal/grievance screen but are uploaded/appended in a separate location. This appears to be the storage used for local plan purposes versus the long term storage referenced above.</p> <p><u>Recommendation for CoventryCares</u> The MCO should request that an appendix/exception be added to the Aetna Medicaid policy and procedure to address the Kentucky-specific requirements.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Coventry should ensure that the Kentucky Contract requirements are addressed in Aetna Policies and Procedures, whether through appending Kentucky-specific information (exceptions) or creating a Kentucky Medicaid specific Policy.</p>	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Upon the next review, IPRO will evaluate the Policies and documentation to ensure same.	
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	Full	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results <u>Member Grievance File Review Results – Random</u> 2 of 11 files reviewed were related to a clinical issue/potential quality of care. 2 of 2 applicable files were reviewed by an appropriate health professional. <u>Member Grievance File Review Results – Quality</u> Only 1 file of 10 files reviewed was related to a clinical issue. 1 of 1 applicable file was reviewed by an appropriate health professional.	
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	Full-2013			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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;				
F. Provide assistance to Members in filing a grievance if requested or needed;	Full-2013			
G. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	<p>Substantial - APP-001, APP-002, APP-003, APP-004 address the requirement that the plan will ensure that punitive or retaliatory action is not taken against a Member or service provider.</p> <p>The Member Handbook, Section 10 states: "CoventryCares of Kentucky does not punish your provider in any way for requesting a fast appeal or for supporting your request for a fast appeal." No information related to grievances was found.</p> <p>Lack of retaliation related to filing appeals and grievances was not found in the Provider Manual or the provider contract.</p> <p>In the prior review, IPRO noted that the Member Handbook and Provider</p>	Non-Compliance	<p>APP-002 Member Appeals, does not address that the MCO will not discriminate against a member based solely on having filed a grievance or appeal. The Policy and Procedure does address lack of retaliation.</p> <p>APP-004 – Member Grievance, does not address that the MCO will not discriminate against a member based solely on having filed a grievance or appeal. The Policy and Procedure does address lack of retaliation.</p> <p>The Member Handbook, Section 10, does not address that the MCO will not discriminate against a member based solely on having filed a grievance or appeal. It does address lack of retaliation, that the MCO will not punish the member or provider for filing a grievance.</p> <p>APP-003 Appeals-Grievances-Providers does not address that the MCO will not</p>	<p><u>MCO Response</u> CoventryCares of KY will add statement to the Provider Manual in the 2016 version stating no punitive action or retaliation will be taken against the member or member's representative for filing an Appeal or Grievance.</p>



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>Manual did not include language that punitive action will not be taken against a Member or service provider who files a grievance or appeal. This was noted only in the Member Handbook as it relates to providers filing or supporting expedited appeals.</p> <p>However, as seen above, the Grievance and Appeal policies (APP-001, 002, 003, 004, 005, 006, and 008) were updated to state that no punitive action or retaliation will be taken towards a member or provider in response to an appeal. This is not limited to the expedited appeal process.</p> <p><u>Recommendation for CCKY</u> CCKY should ensure that no retaliation is communicated to both members and providers related to both appeals and grievances by including this in the respective handbook/manual.</p> <p>MCO Response: CoventryCares of Kentucky will update the Provider Manual and Member Handbook to ensure that punitive action will not be taken against a</p>		<p>discriminate against a member based solely on having filed a grievance or appeal. The Policy and Procedure does address that the MCO will not retaliate against a provider based on filing or supporting an appeal, standard or expedited.</p> <p>Not discriminating against a member based solely on having filed a grievance or appeal was not found in the 2013-2014 or the 2015 Provider Manual, Section 10 Complaints Process Providers and Members.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Coventry should ensure that the statement "the MCO will NOT DISCRIMINATE" against a member/provider based on filing a grievance or appeal to the applicable Policies and Procedures, Member Handbook and Provider Manual.</p> <p>Upon the next review, IPRO will evaluate the Policies, Member Handbook, and Provider Manual to ensure same.</p>	



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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 or service provider who files a grievance or appeal. This will be updated in the Fall 2014 Provider Manual and Member Handbook.			
<p>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.</p> <p>42 CFR 438.410 (b)</p>	<p>Minimal - P/P APP-002 states that CCKY will not take any punitive action or retaliate in any way as a result of a member or member's representative filing or supporting an appeal, whether expedited or otherwise.</p> <p>The Member Handbook states that CCKY will not punish the provider for filing an expedited appeal or supporting the member's expedited appeal request. Retaliation against the member is not addressed.</p> <p><u>Recommendation for CCKY</u> IPRO previously recommended that CCKY include assurance that punitive action will not be taken against a member who requests an expedited appeal in the Member Handbook and policy. P/P AAP-001 addresses the requirement but the Handbook does not.</p> <p>MCO Response: CoventryCares of</p>	Substantial	<p>Addressed in APP-001 Expedited Appeal, APP-002 Member Appeal and APP-004 Member Grievance.</p> <p>Communicated to members in the Member Handbook, Section 10 Grievance and Appeals.</p> <p>Lack of punitive action against members or providers was not found in the Provider Manual, Section 10 Complaints Process Providers and Members.</p> <p><u>Recommendation for CoventryCares</u> The MCO should include a statement regarding lack of punitive action against members or providers in the Provider Manual.</p>	



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	Kentucky will update the Fall 2014 Member Handbook to include assurance that punitive action will not be taken against a member who requests an expedited appeal.			
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-2013			
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 is not satisfied with that decision;	New Requirement	Substantial	<p>Addressed in APP-004 Member Grievance and communicated to members in the Member Handbook.</p> <p>This requirement was not found in the Provider Manual, section 10 Complaint Process for Members and Providers, B. Member Grievance and Appeals Process.</p> <p><u>Recommendation for CoventryCares</u> The MCO should add the required language as it appears in the Member Handbook to the Provider Manual.</p> <p><u>Final Review Determination</u></p>	<p><u>MCO Response</u> Not sure what "required language" they are looking for.</p>



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
			<p>No change in review determination.</p> <p>Coventry should add the specific Contract language that appears in column 1, "J. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;" (Federal requirement 42 CFR 438.420) to the Provider Manual.</p> <p>Upon the next review, IPRO will evaluate the Provider Manual, Member Handbook, and Policies to ensure same.</p>	
<p>K. Provide for continuation of services, if appropriate, while the appeal is pending;</p> <p>The Contractor shall continue the Member's benefits if all of the following are met:</p> <p>(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;</p> <p>(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;</p> <p>(3) the services were ordered by an authorized service provider;</p> <p>(4) the time period covered by the original authorization has not expired; and</p>	<p>Minimal - CCKY revised P/P APP-002 and letter KYGA00008 to include the requirements for continuation of benefits. The 10 day timeframe has been deleted.</p> <p>Member Handbook continues to state that if benefits are to continue during the appeal process, the request must be filed within 10 days.</p> <p>As noted above, CCKY revised its P/P and letter KYGA00008 to meet the requirements for continuation of benefits. However, the 10/2013 version of the Member Handbook still</p>	Substantial	<p>Addressed in APP-002 and communicated to members in the Member Handbook on page 66. CoventryCares revised the Member Handbook to remove the requirement that the request for SFH must be filed within 10 days in order for services to continue. The contract wording regarding continuation of benefits pending appeal or State Fair Hearing has been included in the Member Handbook, page 66.</p> <p>Communicated to providers in the Provider Manual, page 108. The manual states that the member may request continuation of benefits during the appeal review or a</p>	<p><u>MCO Response</u></p> <p>Not sure what "specific conditions in the contract" they are asking for.</p>



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
(5) the Member requests extension of the benefits. 42 CFR 438.420	states that the SFH must be requested within 10 days for benefits to continue. <u>Recommendation for CCKY</u> The Member Handbook should be revised to delete the 10 day timeframe. MCO Response: CoventryCares of Kentucky will revise the Fall 2014 Member Handbook to delete the 10 day timeframe.		State Fair Hearing; however, it does not provide the specific conditions noted in the contract. <u>Recommendation for CoventryCares</u> The MCO should add the specific conditions in the contract to the Provider Manual statement regarding continuation of benefits pending appeal or State Fair Hearing. <u>Final Review Determination</u> No change in review determination. Coventry should add the specific conditions under which benefits will continue pending appeal as stated in column 1, K, 1-5 (Federal requirement 42 CFR 438.420). Upon the next review, IPRO will evaluate the Provider Manual, Member Handbook, and Policies to ensure same.	
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	Full-2014			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p> <p>42 CFR 438.420 KAR 17:010 Section 4 (14)</p>				
<p>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).</p> <p>42 CFR 438.420</p>	Full-2013			
<p>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, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services.</p>	Full-2014			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
42 CFR 438.424				
<p>L. Provide expedited appeals relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being;</p> <p>If the Contractor denies a request for an expedited resolution of an appeal, it shall:</p> <p>(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</p> <p>(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.</p> <p>The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.</p> <p>KAR 17:010 Section 4 (16)</p>	Full-2014			
M. Provide written notice of the appeal decision;	Full-2014			
N. Provide for the right to request a hearing under KRS Chapter 13B; and	Full-2014			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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:</p> <p>(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;</p> <p>(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;</p> <p>(3) the services were ordered by an authorized service provider;</p> <p>(4) the time period covered by the original authorization has not expired; and</p> <p>(5) the Member requests extension of the benefits.</p> <p>42 CFR 438.420</p>	<p>Minimal - CCKY revised P/P APP-002 and letter KYGA00008 to include the requirements for continuation of benefits. The 10 day timeframe has been deleted.</p> <p>Member Handbook continues to state that if benefits are to continue during the appeal process, the request must be filed within 10 days.</p> <p>As noted above, CCKY revised its P/P and letter KYGA00008 to meet the requirements for continuation of benefits. However, the 10/2013 version of the Member Handbook still states that the SFH must be requested within 10 days for benefits to continue.</p> <p><u>Recommendation for CCKY</u> The Member Handbook should be revised to delete the 10 day timeframe.</p> <p>MCO Response: CoventryCares of Kentucky will revise the Fall 2014 Member Handbook to delete the 10 day timeframe.</p>	Substantial	<p>Addressed in APP-002 and communicated to members in the Member Handbook on page 66. CoventryCares revised the Member Handbook to remove the requirement that the request for SFH must be filed within 10 days in order for services to continue. The contract wording regarding continuation of benefits pending appeal or State Fair Hearing has been included in the Member Handbook, page 66.</p> <p>Communicated to providers in the Provider Manual, page 108. The manual states that the member may request continuation of benefits during the appeal review or a State Fair Hearing; however, it does not provide the specific conditions noted in the contract.</p> <p><u>Recommendation for CoventryCares</u> The MCO should add the specific conditions in the contract to the Provider Manual statement regarding continuation of benefits pending appeal or State Fair Hearing.</p> <p><u>Final Review Determination</u> No change in review determination.</p>	<p><u>MCO Response</u> Not sure what "specific conditions in the contract" they are asking for.</p>



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
			<p>Coventry should add the specific conditions under which benefits will continue pending appeal as stated in column 1, O, 1-5 (Federal requirement 42 CFR 438.420).</p> <p>Upon the next review, IPRO will evaluate the Provider Manual, Member Handbook, and Policies to ensure same.</p>	
<p>The Contractor shall provide benefits until one of the following occurs:</p> <p>(1) The Member withdraws the appeal;</p> <p>(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;</p> <p>(3) The Cabinet issues a state fair hearing decision adverse to the Member;</p> <p>(4) The time period or service limits of a previously authorized service has expired.</p> <p>KAR 17:010 Section 4 (14) 42 CFR 438.420</p>	Full-2014			
<p>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</p>	Full-2013			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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				
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, 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	Full-2014			
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-2013			
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	Full-2013			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.				
Documentation regarding the grievance shall be made available to the Member, if requested.	Full-2013			
Grievance File Review				
<p>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.</p> <p>KAR S 17:010 Section 4 (2) (a)</p>	<p>Substantial - P/P APP-004 addresses this requirement</p> <p><u>Grievance File Review</u> File review demonstrated that issues related to acknowledgement letters identified in the prior review have been largely resolved, with the exception of a few cases where the acknowledgement letters were sent late.</p> <p><u>Member Grievance – Random File Review</u> 8 of 10 files acknowledgment letter were sent timely.</p> <p><u>Member Grievance – Quality File Review</u> 9 of 10 files acknowledgment letter were sent timely.</p>	Non-Compliance	<p>Includes Member Random and Member Quality Grievance file review results.</p> <p>Addressed in APP-004 Member Grievance.</p> <p><u>Member Grievance File Review Results – Random</u> 8 of 11 files reviewed met requirements for acknowledgement.</p> <p><u>Member Grievance File Review Results – Quality</u> 10 of 10 files reviewed met requirements for acknowledgement.</p> <p>This element is scored Non-Compliance because the MCO did not address the same recommendation for the prior two reviews.</p>	<p><u>MCO Response</u> CoventryCares of KY has implanted an interdepartmental policy where all grievance resolution letters will be reviewed for proofing and member appropriate language prior to being finalized.</p> <p>Documentation and training of policies and procedures will be reviewed at each staff meeting. There will be a log kept of each training and staff members will have to sign off on the training.</p> <p>Currently have one staff member attending the Aetna Center for Writing Excellence and will have handouts and training in staff meetings for further education of</p>



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
	<p><u>Provider Grievance File Review</u> 5 of 5 acknowledgement letters were sent timely.</p> <p>In response to prior findings, CCKY implemented several new processes and procedures and developed a new system for processing grievances including:</p> <ul style="list-style-type: none"> ▪ Implementation of Quality Check tool for Grievances. Quality Checks are done weekly and metrics are reviewed by senior management with corrective action taken, as needed. ▪ A team member has been assigned responsibility for tracking grievances and ensuring timeliness, compliance, and quality. Other team members are trained as back-up. ▪ The responsible staff member uses daily reports to monitor inquiries coded as grievances and any issues that require action. The staff member checks and if a complaint is closed without all necessary components, the case will be reviewed and re-coded 			staff members.



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>correctly or re-opened as a complaint and acknowledged. The report is viewed by the Manager and Coordinator. A weekly report is sent to the grievance coordinator for another check.</p> <ul style="list-style-type: none"> ▪ A Tracking Log was created to track issues opened as complaints but not worked. The Tracking Log assists the G/A manager to identify staff training issues for both G/A and call center staff. <p>The current file review reflected the improvements.</p> <p>It was noted in the case files that the tracking system was calculating the due dates incorrectly (+/- 1 – 2 days). This did not impact the timeliness of acknowledgements or resolutions for the files reviewed.</p> <p>Recommendation for CCKY Acknowledgment letters should be issued within 5 working days of receipt of the grievance.</p>			



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

Final Findings

Grievance System (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>MCO Response: 1) CCKY has successfully implemented the Grievance Audit tool and has had successful quality scores.</p> <p>2) CCKY has a grievance representative who acts as the liaison between departments regarding grievances. She assembles the electronic files for grievances and makes sure all required communication, research and corrective actions are carried out.</p> <p>3) A tracking log has been required to track errors for CSO and the Grievance Liaison. CCKY has a back-up should the Liaison be out of office.</p> <p>4) The Grievances and Appeals Manager, Grievance Liaison and back-up ALL review daily reports to make sure all necessary communications are sent, and that complaints closed by CSO are caught and handled correctly.</p> <p>*** As an addition, a Complaint Checklist function will be added to our systems. This will allow for additional data to be tracked. It will also prevent CSO, or another third party from</p>			



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>closing an issue coded as a complaint. Only the G&A Department can close the issues. Coding these issues as complaints will also force an issue to be sent to the proper location to be worked. This feature should do away with incorrectly handled complaints.</p>			
<p>The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance.</p> <p>KAR 17:010 Section 4 (2) (b)</p>	Full-2014	Minimal	<p>Includes Member Random and Member Quality Grievance file review results</p> <p><u>Member Grievance File Review Results – Random</u> 9 of 11 files met the standard for timeliness. 7 of 11 files demonstrated a complete investigation. 6 of 11 resolution notices contained all information considered in the investigation. 6 of 11 files contained the findings and conclusions. 11 of 11 files contained the disposition of the grievance 6 of 11 resolution notices were written in a manner to ensure understanding.</p> <p><u>Member Grievance File Review Results – Quality</u> 9 of 10 files met the standard for</p>	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>timeliness. 7 of 10 files demonstrated a complete investigation. 7 of 10 resolution notices contained all information considered in the investigation. 7 of 10 files contained the findings and conclusions. 10 of 10 files contained the disposition of the grievance 7 of 10 resolution notices were written in a manner to ensure understanding.</p> <p>Issues identified among the random and quality grievances, collectively, generally related to the thoroughness and documentation of the investigation, taking appropriate follow-up action and the clarity of the resolution notices. More specifically, there were:</p> <ul style="list-style-type: none"> - 3 cases where the Grievance and Appeal (G/A) staff member accepted providers' verbal explanations without requesting/obtaining supporting documentation; - 1 case where the supporting documentation was not in the file; - 2 cases were misdirected internally, which caused delays; - 1 case was referred to the Provider 	



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

Final Findings

Grievance System (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Relations department and no action until almost 30 days later when the G/A dept followed up;</p> <ul style="list-style-type: none"> - 3 cases where appropriate follow-up action was not taken; - 8 cases where the resolution notices were not written in a manner to ensure ease of understanding; and - 2 cases where a statement was made that the issue was not a CoventryCares error. <p><u>Recommendation for CoventryCares</u> CoventryCares should implement an over-read procedure where letters written by Customer Service Representatives (CSRs) are proof-read for clarity, wording, grammar, spelling and typographical errors and appropriate wording for members prior to being sent.</p> <p>The MCO should share common issues at staff meetings to potentially prevent the same or similar errors occurring by multiple staff members.</p> <p>The MCO should discontinue the practice of copying and pasting internal notes into the resolution notices since the wording</p>	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>may not be appropriate may be awkward, out of context or may not be understood by members. For example, referring to the member in the third person, e.g., "the member reported..." and "the member may..."</p> <p>The MCO should avoid deferring fault by using statements such as "not a health plan error" since this could appear uncaring and offend the member. Better wording would just state the facts.</p> <p>The MCO should avoid the use of managed care "jargon" that members may not understand, e.g., "non-par provider" and "termed."</p>	
<p>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.</p> <p>42 CFR 438.408 (c)</p>	Full-2014	Full	<p>Includes Member Random and Member Quality Grievance file review results</p> <p><u>Member Grievance File Review Results – Random</u> Only 1 file involved an extension. The extension was requested by the member. The file met the timeliness standard and the requirements for member notification.</p> <p><u>Member Grievance File Review Results – Quality</u></p>	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Only 1 file involved an extension. The extension was not requested by the member. The file met the timeliness standard and the requirements for member notification.	
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 to resolve the appeal. KAR 17:010 Section 4 (7)	Full-2014		Includes Member Appeal file review results	
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	Full-2013		Includes Member Appeal file review results	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
timeframe. KAR 17:010 Section 4 (11) and (12)				
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)	Full-2013		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)	Full-2013		Includes Member Appeal file review results	
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.	Full-2014		Includes Member Appeal file review results	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)				
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. 42 CFR 438.408 (e) (2)	Full-2014		Includes Member Appeal file review results	
Expedited Appeals File Review				
The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice. KAR 17:010 Section 4 (14) (c)	Full-2013		Includes review results for Member Appeals if expedited	
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	Full-2013		Includes review results for Member Appeals if expedited	



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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)				
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Full-2013		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 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.	Full-2013			
27.8 Provider Grievances and Appeals				



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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 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.</p>	Full-2014		<p>Includes file review summary results for Provider Grievances and Provider Appeals</p> <p>Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results)</p>	
27. 10 Other Related Processes				



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

Final Findings

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Full-2013			
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 Appeals Narrative (see Quarterly Desk Audit results) Reports #27, #28 and #29 are reviewed with quarterly desk audits conducted by IPRO. Recommendations based on the review are below. <u>Recommendation for CoventryCares</u> Actions taken by the MCO in response to analysis of grievances should be more specific. Issues identified in one quarter should be updated in subsequent quarters until resolved. The narrative report should include total # of grievances received, total # resolved and number/percent of grievances resolved within 30 days. The same issues and actions were reported each quarter. CCKY should assess the	MCO response: More specific details will be included in future reporting.



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

Final Findings

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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
			effectiveness of its actions and implement revised or new actions.	
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	Non-Compliance	No documentation related to this requirement was located.	



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

Final Findings

Grievance System
Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	2	6	3	4
Total Points	6	12	3	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			1.4	

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



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

Final Findings

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data

Process for evaluating patterns of grievances

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: CoventryCares of Kentucky

Final Findings

Health Risk Assessment <i>(See Final Page for Suggested Evidence)</i>				
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)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.	Full-2013			
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 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.	<p>Minimal - P/P CM 022 Health Risk Assessment Member Participation describes the process and procedure for health risk screening for special needs of new members within 90 days of enrollment and 30 days for members believed to be pregnant, who if pregnant will be referred.</p> <p>P/P CM 021 Health Risk Assessment outlines the outreach procedure for health risk assessment that is conducted by the plan's contracted vendor, which includes at least three outreach attempts on three different days and both telephonic and mailed outreach. As noted by the plan in response to last year's findings, this assessment is a screening to assist in stratifying members' risks and the plan improved the process by which new member files are provided to the vendor by the plan. The vendor process for outreach is described in the vendor's NRC Health Risk Assessment Data Collection policy that the plan provided. HRA data are included as</p>	Minimal	<p>Includes HRA file review results</p> <p><u>HRA File Review Results</u> A total of 25 files were reviewed. 12/25 files included evidence of a timely initial outreach attempt. No evidence of outreach was found for the remaining 13 files.</p> <p>10/12 files receiving initial outreach included timely follow-up attempts when the initial attempt was unsuccessful. Follow-up in 2 files was not applicable (member completed HRA at first attempt).</p> <p><u>Recommendation for CoventryCares</u> All new members should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.</p>	<p><u>DMS Response</u> This is the third year in a row that the MCO has received a Minimal in this element. A CAP was issued for this element the past three years with minimal success. DMS has concerns.</p> <p><u>CoventryCares Response</u> Members previously enrolled with another health plan were not excluded from the universe. The health plan will exclude members not eligible for audit in the future.</p>



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>a data source for member identification for case management for members with special health care needs (P/P CM-017) and complex case management (P/P CM-004).</p> <p><u>HRA File Review</u> The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained how frequently timely health screening was conducted. Documentation was received in the form of a call log for 11 members. 5 had at least 3 attempts. 1 had a hang up. 6 had outbound consent which meant that an automated questionnaire was performed. Samples of the HRA were provided. Only attempts to contact member are by phone. 3 members were enrolled prior to auth date and CCKY will look at the logic.</p> <p>NOTE: CCKY stated that only "new" members to Medicaid are required to receive an HRA and that the majority of the members in the sample were existing members from KY Spirit.</p> <p><u>Recommendation for CCKY</u> All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.</p> <p>MCO Response: The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP</p>		<p>Final Review Determination No change in review determination.</p> <p>This was discussed with DMS. Coventry's interpretation of the requirement is incorrect. The requirement is that the MCO is required to conduct/attempt an HRA for ALL members who are newly enrolled in the MCO, and who have not been enrolled in that MCO in the past 12 months, regardless if the member was enrolled in another MCO previously.</p> <p>The intent of the HRA is that the current MCO obtain information on risk factors for the members that are new to that MCO who have not been enrolled in the MCO in the prior 12 months.</p> <p>Each MCO's file review sample is drawn from all members newly enrolled in the MCO. Members who were previously enrolled in another MCO are NOT valid exclusions.</p> <p>It is expected that the MCO provide a full list of new enrollees during the required timeframe as requested. IPRO will remove members who meet exclusion criteria (e.g., enrolled in that MCO in the prior 12 months).</p>	



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach.</p> <p>When IPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP.</p> <p>As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant</p>			



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership.</p> <p>This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.</p>			
<p>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.</p>	<p>Minimal - P/P CM 022 includes reasonable efforts to contact members as per contract language. The process is described in P/P CM 021 and also in the vendor's NRC Health Risk Assessment Data Collection policy. At the onsite CCKY mentioned that they do not outreach in person.</p>	Substantial	<p>Includes HRA file review results</p> <p><u>HRA File Review Results</u> 3/25 members contacted completed an HRA. All 3 HRAs were provided for review. Required components were addressed in 2 files. Current behavioral health status including screening for substance use and</p>	



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained how frequently timely health screening was conducted. Documentation was received in the form of a call log for 11 members. 5 had at least 3 attempts. 1 had a hang up. 6 had outbound consent which meant that an automated questionnaire was performed. Samples of the HRA were provided. Only attempts to contact member are by phone.</p> <p>NOTE: CCKY stated that only “new” members to Medicaid are required to receive an HRA and that the majority of the members on the sample were existing members from KY Spirit.</p> <p><u>Recommendation for CCKY</u> All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.</p> <p>MCO Response: The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each</p>		<p>mental health disorders was lacking in one file.</p> <p><u>Recommendation for CoventryCares</u> The MCO should ensure that all required screening is completed.</p> <p><u>Recommendation for DMS</u> 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.</p> <p>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.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>It is understood that no items in the HRA are mandatory for the member's response. The MCO's HRA should have a method to indicate that a member refused to answer any item and/or if an item is not applicable, whether via written response, phone interview, or other. Without this, it is not clear if the item(s) were skipped or missed inadvertently.</p>	<p><u>CoventryCares Response</u> Members may intentionally choose not to answer all questions in the survey. Vendor does not document why a question was not answered, but this will be part of the process upon migration to Aetna. MCO cannot force member to answer all questions. Future Aetna process will include reasons documented for incomplete assessment.</p>



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach.</p> <p>When iPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP.</p> <p>As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP</p>			



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership.</p> <p>This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.</p>			
<p>Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.</p>	<p>Minimal - P/P CM 022 includes this information to be collected (need for care management, disease management, behavioral health services and/or other health/community services. The Good Health Profiles questionnaire (initial screening) includes current health status, demographics, medications, chronic conditions including behavioral conditions, and behavioral risks. The plan provided a template Child Health Screening Tool that addresses all required areas in detail, and a Maternity Health Profiles that is also very detailed and targeted to obstetric risks. These two documents include detailed demographic information.</p> <p>The plan did not provide any files for review of</p>	Minimal	<p>Includes HRA file review results</p> <p><u>HRA File Review Results</u> Incomplete demographic information was evident in all 3 files that included a completed HRA. Current behavioral health status including screening for substance use and mental health disorders was lacking in one file.</p> <p><u>Recommendation for CoventryCares</u> The MCO should ensure that all required screening is completed and that the HRA includes complete demographic information.</p>	<p><u>CoventryCares Response</u> The vendor is able to submit "Good Health Profiles" at next audit.</p>



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>the 25 members in the sample. It could not be ascertained whether demographic information would be included.</p> <p><u>Recommendation for CCKY</u> All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.</p> <p>MCO Response: The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach.</p> <p>When iPro pulled the universe of new members</p>		<p>Final Review Determination No change in review determination.</p> <p>Coventry needs to clarify the response.</p>	



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

Final Findings

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>for CoventryCares, the majority of the “new” members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member’s first MCO – in this case, KSHP.</p> <p>As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership.</p> <p>This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have</p>			



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

Final Findings

Health Risk Assessment <i>(See Final Page for Suggested Evidence)</i>				
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
	erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.			
The Contractor shall use appropriate healthcare professionals in the assessment process.	Full-2013			
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-2013		Includes review of MCO Report #79 Health Risk Assessments	



Final Findings

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

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	0	1	2	0
Total Points	0	2	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			1.33	

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



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

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: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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				
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-2013			
defining the scope of providers covered,	Full-2013			
the criteria and the primary source verification of information used to meet the criteria,	Full-2013			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Full-2013			
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.	Full-2013			
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-2013			
Providers required to be recredentialled by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists,	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.				
The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The Contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.	Full-2013			
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.	Full-2013			
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-2013			
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	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
accordance with the Department's policies and procedures.				
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;	Full-2013			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full-2013			
C. A review of the credentialing policies and procedures by the formal body;	Full-2013			
D. A credentialing committee which makes recommendations regarding credentialing;	Full-2013			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full-2013			
F. Written procedures for the termination or suspension of Providers; and	Full-2013			
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Full-2013			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of	Substantial - P/P CP – 001 Provider Types, Requirement, Rights address	Full	Includes Credentialing file review summary results	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

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 Providers credentials shall include the following:	<p>this requirement.</p> <p><u>Credentialing File Review</u> IPRO reviewed 10 PCP credentialing files and 10 Specialist credentialing files with the following results:</p> <p><u>PCP Files</u> 10/10 files reviewed were fully compliant.</p> <p><u>Specialist Files</u> 8/10 files were compliant. 1 specialist – Recredentialed after 3 years 2 months.</p> <p>1 specialist – No signed attestation. No evidence of credentialing. MCO states that facility conducts credentialing for this specialist.</p> <p>Overall, although information was presented, the files were inconsistently organized. Provider information was stored in both the Corporate and MCO systems which prevents the MCO from maintaining one complete, consistent provider file.</p> <p>Recommendation for CCKY Files provided should include complete most up to date information. The MCO should include copies of the most</p>		<p>This requirement is addressed in the Credentialing Policy.</p> <p><u>Credentialing File Review Results</u> Initial Credentialing 10/10 files reviewed were fully compliant</p> <p>Recredentialing 10/10 files reviewed were fully compliant</p> <p>All files were consistently organized and utilized a coversheet which aids in the monitoring of timeframes, content and file completion.</p>	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

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
	<p>recently signed attestation with the provider files.</p> <p>MCO Response: Effective 7/21/2014, hiring of a SR Credentialing Analyst onsite at the Health Plan will provide resolution moving forward. Responsibilities of this role will include verification of all provider credentials, ongoing monitoring and managing of provider credentialing files in accordance with P/P CP- 001 Provider Types, Requirement, and Rights.</p>			
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Full-2013			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full-2013			
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	Full-2013			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full-2013			
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

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
F. Previous five (5) years work history;	Full-2013			
G. Professional liability claims history;	Full-2013			
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Full-2013			
I. Current, adequate malpractice insurance, as verified through attestation;	Full-2013			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full-2013			
K. Documentation of curtailment or suspension of medical staff privileges;	Full-2013			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full-2013			
M. Documentation of censure by the State or County professional association; and	Full-2013			
N. Most recent information available from the National Practitioner Data Bank.	Full-2013			
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-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
B. Lack of present illegal drug use;	Full-2013			
C. History of loss of license and felony convictions;	Full-2013			
D. History of loss or limitation of privileges or disciplinary activity;	Full-2013			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full-2013			
F. Applicant attests to correctness and completeness of the application	Full-2013			
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;	Full-2013			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Full-2013			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full-2013			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Full-2013			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
contract.				
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-2013			
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:	Full-2013		Includes Recredentialing file review summary results	
A. A current license to practice;	Full-2013			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full-2013			
C. A valid DEA number, if applicable;	Full-2013			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full-2013			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Full-2013			
F. A current signed attestation statement by the applicant regarding:	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
1. The ability to perform the essential functions of the position, with or without accommodation;	Full-2013			
2. The lack of current illegal drug use;	Full-2013			
3. A history of loss, limitation of privileges or any disciplinary action; and	Full-2013			
4. Current malpractice insurance.	Full-2013			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Full-2013			
A. The national practitioner data bank;	Full-2013			
B. Medicare and Medicaid;	Full-2013			
C. State boards of practice, as applicable; and	Full-2013			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full-2013			
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-2013			
The Contractor shall establish ongoing monitoring of	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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 sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Full-2013			
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-2013			
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-2013			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Full-2013			
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	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
review in support of the State Medicaid credentialing process.				
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full-2013			
28.1 Network Providers to be Enrolled				
<p>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.</p> <p>In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid</p>	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
<p>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.</p> <p>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.</p> <p>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.</p>				



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
<p>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.</p>				
<p>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.</p>	Full-2013			
<p>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.</p>	Full-2013			
<p>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.</p>	Full-2013			
<p>The Contractor must offer participation agreements</p>	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
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.				
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.	Full-2013			
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	Full-2013			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
<p>the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.</p>				
<p>28.4 Enrolling Current Medicaid Providers</p>				
<p>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.</p>	<p>Full-2013</p>			



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
28.5 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 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.	Full-2013			
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-2013			
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 Manual.	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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 the Department of termination from Contractor's network taken against a Provider within three business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full-2013			
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	Full	This requirement is addressed in the Member Handbook.	
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 to the Department the reason or reasons for which the PCP ceases participation.	Full-2013			
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	Full	This requirement is addressed in the Member Handbook.	
C. The Contractor may terminate from participation	Not Reviewed	Full	This requirement is addressed in the Provider	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
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
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.			Manual and the Provider Agreement.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider 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 Member Handbook.	



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky (CCKY)**

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	6	0	0	0
Total Points	18	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 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



KY EQRO ANNUAL REVIEW

March 2015

Period of Review: January 1, 2014 – December 31, 2014

MCO: CoventryCares of Kentucky (CCKY)

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: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
27.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.	Full-2013			
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.	Full-2013			
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's				



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

Final Findings

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
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
polices including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Full-2013			
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;	Full-2013			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full-2013			
D. Discussing Advance Medical Directives with all Members as appropriate;	Full-2013			
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;	Full-2013			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full-2013			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full-2013			
Maintaining formalized relationships with other PCPs to refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Full-2013			
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by				



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;	Full-2013			
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and	Full-2013			
(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-2013			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Full-2013			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Full-2013			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Full-2013			
(4) Returning after-hours calls outside of thirty (30) minutes.	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
28.7 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-2013			
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.	Full-2013			
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:	Full-2013			
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-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	



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

Final Findings

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
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
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 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.	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly 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-2013			
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-2013		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	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly	



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

Final Findings

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
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
documented by the Contractor. Appointment and waiting times shall not exceed 3 weeks for regular appointments and 48 hours for urgent care.			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 hours for Urgent Care.	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps(see Quarterly Desk Audit results)	
H. Access for Pharmacy services shall not exceed 60 miles or 60 minutes or the delivery site shall not be further than 50 miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.	Full-2013		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-2013			
B. FQHCs and rural health clinics;	Full-2013			
C. The Kentucky Commission for Children with Special Health Care Needs; and	Full-2013			
D. Community Mental Health Centers	Full-2013			
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	Full-2014			



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

Final Findings

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
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
specified providers.				
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 provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.	Full-2013			
B. Provide reimbursement at rates commensurate with those provided under Medicare.	Full-2013			
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			



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
28.8 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 anticipated network changes that may impact network standards herein.	Full-2013		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
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-2013		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	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
the Contractor's terms and conditions.				
30.1 Medicaid Covered Services				
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-2013			
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-2013			
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				



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder 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-2013			
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	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
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
require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.				
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Full-2013			
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-2013			
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.	Full-2013			
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. Post	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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-2013			
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.	Full-2013			
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-2013			
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member				



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Full-2013			
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Substantial - This is addressed in the Member Handbook under Direct Access Services. P/P UM-020 does not address oral surgery services and evaluations. Recommendation for CCKY As noted last year, oral surgery services and evaluations by orthodontists and prosthodontists should be added to P/P UM-020. MCO Response: P/P UM-020 has been updated to include oral surgery services and is on the agenda for the next Policies and Procedures meeting to review and approve.	Full	This requirement is addressed in the Member Handbook and also in the UM Direct Access Service Policy.	
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full-2013			
D. Maternity care for Members under 18 years of age;	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
E. Immunizations to Members under 21 years of age;	Full-2013			
F. Sexually transmitted disease screening, evaluation and treatment;	Full-2013			
G. Tuberculosis screening, evaluation and treatment;	Full-2013			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Full-2013			
I. Chiropractic services; and	Full-2013			
J. Women's health specialists.	Full-2013			
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-2013			
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-2013			
All information shall be provided to the Member in a	New Requirement	Minimal	The requirement that all information be	



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

Final Findings

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>			<p>provided to members in a confidential manner is found in the Member Handbook and the Provider Manual.</p> <p>Missing from the documentation was the regulatory language pertaining to counseling and medical services. Onsite, Coventry added the missing regulatory language to its Family Planning Services and Treatment for Sexually Transmitted Diseases Policy.</p> <p><u>Recommendation for Coventry</u> Coventry should add the regulatory language pertaining to counseling and medical service appointments to its Provider Manual and Member Handbook.</p>	<p><u>MCO Response</u> Coventry will add the regulatory language pertaining to counseling and medical service appointments to its Provider Manual and Member Handbook for 2015.</p>



**KY EQRO ANNUAL REVIEW
March 2015**

**Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky**

Final Findings

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



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

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

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



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

Final Findings

- 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: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
20.6 Utilization Management				
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-2013			
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Full-2013			
The description shall include the scope of the program;	Full-2013			
the processes and information sources used to determine service coverage;	Full-2013			
clinical necessity, appropriateness and effectiveness;	Full-2013			
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-2013			
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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 QJ Committee.	Full-2013			
The Contractor shall adopt Interqual, Milliman or other nationally recognized standards and criteria for Medical Necessity review which shall be approved by the Department.	Full-2013			
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.	Full-2013			
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-2013			
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Full-2013		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-2013		Includes UM file review results	



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The reason for the denial shall be cited.	Full-2013		Includes UM file review results	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.	Full-2013			
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.	Full-2013			
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Full-2013			
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.	Full-2013			
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-2013			
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.	Full-2013			
F. The Contractor shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.	New Requirement	Substantial	<p>The Technology Assessment (7000.20) policy and procedure does not state that the plan will only provide coverage for randomized and controlled Phase III and Phase IV clinical trials, but states that criteria are considered in evaluating medical technologies, such as "Is the medical technology being tested in a randomized and controlled Phase III or Phase IV clinical trial.</p> <p>However, during the onsite review, the MCO provided a revised copy of The Technology Assessment (7000.20) policy and procedure which includes the language that the MCO shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.</p> <p><u>Recommendation for CoventryCares</u> The policy revisions should be approved and implemented.</p>	<p><u>MCO Response</u></p> <p>The Technology Assessment (7000.20) policy will be updated and approved with the language the plan will only provide coverage for randomized and controlled Phase III and Phase IV clinical trials</p>
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	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
deny, limit, or discontinue medically necessary services to a Member.				
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 provision of medical services.	Full-2013			
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Full-2013			
The UM program will be evaluated by DMS on an annual basis.	Full-2013		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 of 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-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(a) The action the Contractor has taken or intends to take;	Full-2013		Includes UM file review results	
(b) The reasons for the action in clear, non-technical language that is understandable by a layperson;	Full-2013		Includes UM file review results	
(c) The federal or state regulation supporting the action, if applicable;	New Requirement	Full	Includes UM file review results No UM files reviewed while onsite because it was deemed for this review. This requirement is addressed on page 1 of the Notifications of Utilization Review Denial Decisions for Medicaid/NOA for Service Authorizations policy and procedure and Notifications of Utilization Review Decisions for Commercial and Medicaid Policy. The Utilization Management Program Description on page 27 states that staff consults guidelines from sources such as applicable state and federal guidelines.	
(d) The Member's right to appeal;	Full-2013		Includes UM file review results	
(e) The Member's right to request a State hearing;	Full-2014		Includes UM file review results	
(f) Procedures for exercising Member's rights to Appeal or file a Grievance;	Full-2013		Includes UM file review results	
(g) Circumstances under which expedited resolution is available and how to request it; and	Full-2013		Includes UM file review results	
(h) The Member's rights to have benefits continue	Substantial - Addressed in Member	Full	Includes UM file review results	



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.	<p>Handbook. P/P UM-008 Notice of Action does not address this requirement.</p> <p><u>Recommendation for CCKY</u> P/P UM-008, Notice of Action should be revised to include continuation of benefits.</p> <p>MCO Response: P/P UM-008 has been updated to include continuation of benefits and is on the agenda for the next Policies and Procedures committee meeting for review and approval.</p>		<p>No UM files reviewed while onsite because it was deemed for this review.</p> <p>This requirement is addressed on page 66 of the Member Handbook and the Notifications of Utilization Review Denial Decisions for Medicaid/NOA for Service Authorizations P/P on page 2.</p>	
20.8 Timeframe for Notice of Action Related to Medical Necessity or Coverage Denials				
<p>The Contractor must give notice of an Action related to medical necessity or coverage denials at least:</p> <p>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.</p>	Full-2013			
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Full-2013			
3. The Member's admission to an institution where he is ineligible for further services;	Full-2013			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Full-2013			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Full-2013			
6. The Member's physician prescribes the change in the level of medical care;	Full-2013			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Full-2013			
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.	Full-2013			
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.	Full-2013			
D. The Contractor must give notice as expeditiously	Full-2013		Includes UM file review results	



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.				
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.	Full-2013		Includes UM file review results	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.	Full-2013			
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for	Full-2013			



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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.				



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

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	2	1	0	0
Total Points	6	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		2.67		

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



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

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: CoventryCares of Kentucky

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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				
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-2013			
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;	Full-2013			
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;	Full-2013			
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;	Full-2013			
D. Effective lines of communication between the compliance officer and the organization's	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
employees;				
E. Enforcement of standards through disciplinary guidelines;	Full-2013			
F. Provision for internal monitoring and auditing of the member and provider;	Full-2013			
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;	Full-2013			
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;	Full-2013			
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full-2013			
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;	Full-2013			
K. Contractor shall provide procedures for appeal process;	Full-2013			
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
M. Contractor shall create a process for card sharing cases;	Full-2013			
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;	Full-2013		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-2013			
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2013			
The plan shall be made available to the Department for review and approval.	Full-2013			
9.1 Administration/Staffing				
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	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
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.				
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-2013			
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, 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:	Full-2014		Includes review of individual disclosures	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or	Full-2014		Includes review of individual disclosures	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
(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;				
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-2013		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-2013		Includes review of individual disclosures	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Full-2014		Includes review of individual disclosures	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
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	<p>Non-Compliance - The ADO documentation provided did not address any employment activities with the Commonwealth.</p> <p><u>Recommendation for CCKY</u> ADO documentation should include disclosure of employment with the Commonwealth or any of its agencies.</p> <p>MCO Response: All employees are screened and attest to any employment that may cause a conflict of interest. Every applicant is specifically asked if they have any employment history with the Commonwealth of Kentucky and to disclose what that employment relationship was. Any questionable relationship is escalated from the recruiter to the plan Compliance Officer and Legal Counsel for review of conflicts. These must be signed off on before hiring can continue. All Board of Directors, Officers, and any person with an ownership or controlling interest is required to complete and submit conflict of interest to corporate compliance/legal. Anyone who had employment with the Commonwealth and their employment relationship cannot easily assessed is asked to obtain a release from the KY Ethics Review Board.</p>	Full	<p>This requirement is addressed in Coventry's Program Integrity Plan.</p> <p>Coventry's employees attest to any employment that may cause or create a conflict of interest. Prior to on-boarding, all applicants are asked if their employment history includes work with the Commonwealth of Kentucky and to disclose the nature of such a relationship. All relationships are escalated from Human Resources to Coventry's Compliance Officer and Legal Counsel for a conflicts of interest review.</p> <p>All Board of Directors, Officers and/or any person with an ownership or controlling interest is required to complete and submit a conflict of interest disclosure to corporate or legal on an ongoing basis. Releases from the Kentucky Ethics Review Board need to be obtained for applicants whose employment relationship cannot be easily assessed.</p>	
G. The Contractor shall be required to notify the Department immediately when any change in	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
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.				
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-2013			
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-2013			
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with Federal and State requirements;	Full-2013			
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full-2013			
E. The unit prioritizes work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority.	Non-Compliance - As part of the onsite interview it was noted that CCKY does not have a written policy regarding prioritization.	Non-Compliance	The documentation provided does not meet the requirement.	DMS Response In 2013, this element received a Non-Compliance and again in 2014 and 2015. The



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
<p>Allegations or cases having the greatest program impact include cases involving:</p>	<p>The Program Integrity (PI) Plan is across all of Coventry national.</p> <p>During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY was to provide a document that detailed the logic, but it was not received.</p> <p>Recommendation for CCKY CCKY should prepare a document addressing the prioritization of the Fraud, Waste and Abuse (FWA) process for the KY contract.</p> <p>MCO Response: The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.</p> <p>"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p>		<p>The plan does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national.</p> <p>During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) prioritizes membership /patient harms issues but no formal policy exists.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of prioritization of cases for investigation in the Policy.</p> <p>A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address prioritization of cases for investigation.</p> <p>No documentation to address prioritization of cases based on "Allegations or cases having the greatest program impact" was provided.</p> <p>Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the</p>	<p>Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with for the 2015 review. DMS has concerns.</p> <p>MCO Response Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases.</p>



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>		opening, during the interviews, and finally at the closing.	
<p>(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;</p>	<p>Non-Compliance - It was noted at the onsite interview that CCKY is a multi state organization that shares information among state lines of business. The MCO participates in USDOJ quarterly meetings and private State quarterly meetings regarding specific providers.</p> <p>CCKY performs data mining to provide cases to the State on a quarterly basis. Algorithms are given to State.</p> <p><u>Recommendation for CCKY</u> CCKY should document the prioritization process for the KY contract in a policy and procedure.</p>	Non-Compliance	<p>The documentation provided does not meet the requirement.</p> <p>The plan did not provide a policy document that describes the prioritization process for the KY contract.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of prioritization of cases for investigation in the Policy.</p>	<p><u>DMS Response</u> In 2013, this element received a Non-Compliance and again in 2014 and 2015. The Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with 2015 review. DMS has concern.</p> <p><u>MCO Response</u> Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases.</p>



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>MCO Response: The CoventryCares policy, "SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.</p> <p>"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>		<p>A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address prioritization of cases for investigation.</p> <p>No documentation to address prioritization of cases based on "(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;" was provided.</p> <p>Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the opening, during the interviews, and finally at the closing.</p>	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(2) High dollar amount of potential overpayment; or	Non-Compliance – See above.	Non-Compliance	<p>The documentation provided does not meet the requirement.</p> <p>The plan did not provide a policy document that addresses this requirement.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of prioritization of cases for investigation in the Policy.</p> <p>A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address prioritization of cases for investigation.</p> <p>No documentation to address prioritization of cases based on "High dollar amount of potential overpayment;" was provided.</p> <p>Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the opening, during the interviews, and finally at the closing.</p>	<p><u>DMS Response</u> In 2013, this element received a Non-Compliance and again in 2014 and 2015. The Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with 2015 review. DMS has concern.</p> <p><u>MCO Response</u> Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases.</p>



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Non-Compliance – See above.	Non-Compliance	<p>The documentation provided does not meet the requirement.</p> <p>The plan did not provide a policy document that addresses this requirement.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of prioritization of cases for investigation in the Policy.</p> <p>A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address prioritization of cases for investigation.</p> <p>No documentation to address prioritization of cases based on "(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern" was provided.</p> <p>Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the opening, during the interviews, and finally at the closing.</p>	<p><u>DMS Response</u> In 2013, this element received a Non-Compliance and again in 2014 and 2015. The Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with 2015 review. DMS has concern.</p> <p><u>MCO Response</u> Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases.</p>



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full-2013			
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2013			
FUNCTION: Contractor and/or Contractor's PIU shall:				
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Full-2013			
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-2013			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full-2013			
D. Initiate appropriate administrative actions to collect overpayments;	Full-2013			
E. Refer potential Fraud, Waste and Abuse cases to	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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 OIG with copy to the Department for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;				
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;	Full-2013			
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Full-2013			
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Full-2013			
I. Provide for internal monitoring and auditing of Contractor and its 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-2013			
K. Create an accounts receivable process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the Department.	Full-2013		Includes review of MCO Report #71 Provider Outstanding Account Receivables	
L. Allow the Department to collect and retain any	New Requirement	Non-Compliance	The documentation provided does not meet	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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 if the Contractor has not taken appropriate action to collect the overpayment after 180 days;			the requirement.	
M. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;	Full-2013			
N. Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;	Full-2013			
O. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Full-2013			
P. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Full-2013			
Q. Designate a contact person to work with investigators and attorneys from the Department and OIG;	Full-2013			
R. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Full-2013			
S. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member	Full-2013		Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB)	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
T. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;	Full-2013		Includes review of MCO Report #75 SUR Algorithms	
U. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Full-2013			
V. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review and approval;	Full-2013			
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-2013			
Y. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department; and	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
Z. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.	Full-2013			
<p>PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law with copy to the Department and OIG.</p>	<p>Non-Compliance - The Program Integrity Plan states that cases involving member safety (abuse) are reported to the health plan medical director for review. The Plan does not address requirement for notifying DCBS, DMS and OIG.</p> <p><u>Recommendation for CCKY</u> P/P should address notification requirements.</p> <p>MCO Response: The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.</p> <p>"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will</p>	Non-Compliance	<p>The Program Integrity Plan states that cases involving member safety (abuse) are reported to the health plan medical director for review.</p> <p>The Plan does not address requirement for notifying DCBS, DMS and OIG.</p> <p>Policy and Procedure COM-001 Compliance Committee states that the roles and responsibilities of the Compliance Committee include timely and consistent communication with the Department's Program Integrity Unit, AG MFCU, OIG and reporting to the Department and OIG immediately any suspicion/[knowledge] of fraud or abuse. This does not specifically address patient abuse and does not address reporting to DCBS.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Policy and Procedure RR002 does not relate to Fraud, Waste, and Abuse or SIU</p>	<p><u>DMS Response</u> In 2013, this element received a Non-Compliance and again in 2014 and 2015. The Corrective Action Plan that was written in 2014 included Policy Changes. Those policy changes and documentation were not submitted with 2015 review. DMS has concern.</p> <p><u>MCO Response</u> Policy RR002 has been updated and approved to address the prioritization of the Special Investigation Units reviews/cases.</p>



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>		<p>investigations. The title of the policy is "Member Rights and Responsibilities". There is no mention of prioritization of cases for investigation in the Policy. There is no mention of patient abuse in this Policy.</p> <p>A document KY-001 "SIU Medical Case Process" was submitted on 3/17/15. This document does not address reporting patient abuse. There are general statements regarding referrals to law enforcement and governmental agencies. Additionally, "abuse" in this document is defined only related to payment.</p> <p>The Program Integrity Plan 2013 was submitted on 3/17/15. This document contains the same statement regarding reporting cases involving member's health or safety to the Medical Director. This document also addresses routine, monthly reporting to the State. The related Exhibit 2 Health Care & Pharmacy Anti-Fraud, Waste and Abuse Guide indicates only generally SIU reporting to a governmental agency. Abuse is referenced only in terms of payment in this Plan and the Exhibits.</p> <p>Coventry did not submit any Policy or document that includes the language "If the investigation indicates an imminent threat to member safety or a significant projected</p>	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
			<p>portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>Policies and Procedures CM-033 and CM-034 were submitted by Coventry for the Case Management review domain. These Policies were not referenced in relation to Program Integrity; therefore, they were not reviewed. Also note that these Policies do not address reporting to the Department and/or OIG.</p> <p>Coventry was informed that the Policies and Procedures submitted did not meet the requirements three times – during the opening, during the interviews, and finally at the closing.</p>	
<p>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:</p>				
A. Upon receipt of a complaint or other indication of	Full-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
potential Fraud or Abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;				
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Full-2013			
C. If the preliminary inquiry results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments;	Full-2013			
D. If the preliminary inquiry results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the OIG, with a copy to the Department;	Full-2013			
E. OIG will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;	Full-2013			
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-2013			



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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
G. If the OIG determines that it will keep a case referred by the PIU, the OIG will conduct a preliminary investigation, gather evidence, write a report and forward information to the Department, the PIU, or, if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate actions;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;	Full-2013			
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-2013		Includes Program Integrity file review results	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(2) Medicaid identification number,	Full-2013		Includes Program Integrity file review results	
(3) Source of complaint,	Full-2014		Includes Program Integrity file review results	
(4) State the complaint/allegation,	Full-2013		Includes Program Integrity file review results	
(5) Date assigned to the investigator,	Full-2013		Includes Program Integrity file review results	
(6) Name of investigator,	Full-2014		Includes Program Integrity file review results	
(7) Date of completion,	Full-2013		Includes Program Integrity file review results	
(8) Methodology used during investigation,	Full-2013		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-2013		Includes Program Integrity file review results	
(12) Identify overpayment, if any, and recommendation concerning collection,	NA - No cases presented for overpayment.		Includes Program Integrity file review results	
(13) Any other elements identified by CMS for fraud referral;	New Requirement	Non-Compliance	The documentation provided does not meet the requirement.	
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;	Full-2013		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report	
M. The Contractor's PIU shall maintain access to a	Full-2013			



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

Final Findings

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follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and				
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full-2013			
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 suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.	Full-2013		Includes review of MCO Report #76 and Report #77	
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:	Full-2013		Includes review of MCO Report #76 and Report #77	
(1) PIU Case number;	Full-2013		Includes review of MCO Report #76 and Report #77	
(2) OIG Case number (if one has been assigned);	Full-2013		Includes review of MCO Report #76 and Report #77	
(3) Provider/Member name;	Full-2013		Includes review of MCO Report #76 and Report #77	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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(4) Provider/Member number;	Full-2013		Includes review of MCO Report #76 and Report #77	
(5) Date complaint received by Contractor;	Full-2013		Includes review of MCO Report #76 and Report #77	
(6) Source of complaint, unless the complainant prefers to remain anonymous;	Full-2013		Includes review of MCO Report #76 and Report #77	
(7) Date opened and name of PIU investigator assigned;	Full-2013		Includes review of MCO Report #76 and Report #77	
(8) Summary of complaint;	Full-2013		Includes review of MCO Report #76 and Report #77	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);	Full-2013		Includes review of MCO Report #76 and Report #77	
(10) PIU action taken and date (only provide the most current update);	Full-2013		Includes review of MCO Report #76 and Report #77	
(11) Amount of overpayment (if any) and time span;	Full-2013		Includes review of MCO Report #76 and Report #77	
(12) Administrative actions taken to resolve findings of completed cases;	Full-2013		Includes review of MCO Report #76 and Report #77	
(13) The overpayment required to be repaid and overpayment collected to date;	Full-2013		Includes review of MCO Report #76 and Report #77	
(14) Describe sanctions/withholds applied to Providers/Members, if any;	Full-2013		Includes review of MCO Report #76 and Report #77	
(15) Provider/Members appeal regarding overpayment or requested sanctions. List the date an appeal was requested, date the hearing was held,	Full-2013		Includes review of MCO Report #76 and Report #77	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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 date and decision of the final order;				
(16) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented revision and date of implementation; and	Full-2013		Includes review of MCO Report #76 and Report #77	
(17) Make MIS system edit and audit recommendations as applicable.	Full-2013		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;	<p>Non-Compliance - P/Ps provided do not address requirement. Interviewer requested the retention policy at the onsite, but it was not provided.</p> <p><u>Recommendation for CCKY</u> CCKY should address record retention requirements in a policy/procedure.</p> <p>MCO Response: As the plan migrates to the Aetna platform the Records Retention and Destruction policy approved 5/22/14 will be adopted for CoventryCares of Kentucky.</p> <p>Today, Privacy-016, Storage and Disposal of Hardcopy PII/PHI includes language on records retention as well as UM-31, Clinical Record and Confidentiality and IS-004 Data Availability and Storage.</p>	Full	This requirement is addressed in the Records Retention and Destruction Procedures.	



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

Final Findings

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;	Full-2013			
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;	Full-2013			
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or the OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;	Full-2013			
E. Produce records in electronic format for review and manipulation by the Department and the OIG;	Full-2013			
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;	Full-2013			
G. Provide the Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;	Full-2013			
H. Fully cooperate with the Department, the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or Fraud or Abuse cases; and	Full-2013			



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

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	7
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				0.67

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



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

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: CoventryCares of Kentucky

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
32.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment				
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix J. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Full-2013		Includes review of MCO Report #93 EPSDT CMS-416	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Full-2013			
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-2013			
Members and their families shall be informed about EPSDT and	Full-2014		Includes file review results for EPSDT UM	



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

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.			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-2013			
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.	Full-2013			
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers shall provide treatment if the service is not available with the Contractor's Network.	Full-2013			
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 these services. Current requirements for EPSDT Special Services are included in Appendix J.	Full-2013			



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

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>	<p>Substantial - This is addressed in the NavCare system. The EPSDT Team has chosen to utilize this system to track all inbound and outbound based telephonic conversations with families.</p> <p>Policy CM-025 EPSDT Referrals presents the process for ensuring timely member compliance. Members are identified through the Cognos PCP Member Detail Report for well child visits. The coordinator follows up with members who have not been compliant with referral appointments for EPSDT services. A consolidated record is maintained in NavCare for each member. A NavCare screen shot along with the process was provided.</p> <p>A sample Cognos report was to be presented during the onsite visit but was not provided.</p> <p><u>Recommendation for CCKY</u> A sample Cognos report should be provided for review.</p>	<p>Full</p>	<p>In the pre-onsite documents, CoventryCares provided a draft EPSDT tracking system for monitoring acceptance and refusal of EPSDT services using the NavCare (clinical) and Navigator (customer contact) systems. Its stated purpose is to track communications, e.g., inbound/outbound telephone, member-specific mailings, EPSDT program mailings.</p> <p>During the onsite interview, CoventryCares indicated that the system is operational and can monitor acceptance/refusal and receipt or gaps in EPSDT services and EPSDT special services. The procedure for use was explained and how reports can be run.</p> <p>As requested, CoventryCares provided screen prints that displayed the system functionality as well as reports from the system. The tracking system can access demographics, enrollment, benefits, claims, authorizations, history, provider(s), outreach attempts (both telephone and mailed), case management, and tracking of HEDIS measure compliance for applicable measures.</p> <p>The MCO also provided 2 reports, a report listing all 2 year old members with lead results > 5 mg/dl and a report of all 1 year old members non-compliant with well child</p>	



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

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>MCO Response: CoventryCares of Kentucky will ensure that all reports are presented during future onsite, as requested. A CoventryCares of Kentucky compliance trend report from Cognos is being submitted for the EQRO's files.</p>		<p>visits.</p> <p>In the pre-onsite documents, the MCO also provided job description for a QM Project Manager, EPSDT; however a posting date was not found and it is not clear if the position has been filled. During the interview, CCKY confirmed that the position had been filled and the QM Project Manager, EPSDT attended the onsite interview.</p>	
<p>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.</p>	Full-2013			
<p>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.</p>	Full-2013			



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

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.	Full-2013			
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.				
K. Participate in any state or federally required chart audit or quality assurance study.	Full-2013			
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			



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

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i>				
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
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.	Full-2013			
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-2013		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: CoventryCares of Kentucky

Final Findings

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	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



KY EQRO ANNUAL REVIEW

March 2015

Period of Review: January 1, 2014 – December 31, 2014

MCO: CoventryCares of Kentucky

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: CoventryCares of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.	Full-2013		Includes review results for each subcontractor	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Full-2014		Includes review results for each subcontractor	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	Full-2014		Includes review results for each subcontractor	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Full-2014		Includes review results for each subcontractor	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.	Full-2013		Includes review results for each subcontractor	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.	Full-2014			



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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.	Full-2013		Includes review results for each subcontractor	
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.	Full-2013		Includes review results for each subcontractor	
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management,	Full-2013		List subcontractors contracted with the MCO and type of services provided	



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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>or otherwise interact with a Member. Such Subcontractors must be eligible for participation in the Medicaid program as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.</p>				
<p>The Department's subcontract review shall assure that all Subcontracts:</p>				
<p>A. Identify the population covered by the Subcontract;</p>	<p>Full-2013</p>		<p>Includes review results for each</p>	



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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			subcontractor	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Full-2013		Includes review results for each subcontractor	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Full-2013		Includes review results for each subcontractor	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Full-2013		Includes review results for each subcontractor	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Full-2013		Includes review results for each subcontractor	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Full-2013		Includes review results for each subcontractor	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Full-2013		Includes review results for each subcontractor	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	Full-2013		Includes review results for each subcontractor	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;	Full-2013		Includes review results for each subcontractor	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the	Full-2013		Includes review results for each subcontractor	



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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Department's specifications required by this Contract;				
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,	Full-2013			
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,	Full-2013		Includes review results for each subcontractor	
(2) all QAPI requirements,	Full-2013		Includes review results for each subcontractor	
(3) all record keeping and reporting requirements,	Full-2013		Includes review results for each subcontractor	
(4) all obligations to maintain the confidentiality of information,	Full-2013		Includes review results for each subcontractor	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,	Full-2013		Includes review results for each subcontractor	
(6) all indemnification and insurance requirements, and	Full-2013		Includes review results for each subcontractor	
(7) all obligations upon termination;	Full-2013		Includes review results for each subcontractor	



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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;	Full-2013		Includes review results for each subcontractor	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	Full-2014		Includes review results for each subcontractor	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Full-2013		Includes review results for each subcontractor	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Full-2013		Includes review results for each subcontractor	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Full-2013		Includes review results for each subcontractor	
Section 6.2 requirements would be applicable to Subcontractors characterized as Risk Arrangements. Section 6.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.	Full-2013			
6.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any	Substantial – No evidence of an update to the	Minimal	Coventry submitted copies of their	<u>DMS Response</u>



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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of \$25,000 or five percent (5%) of the Subcontractor's operating expense.</p>	<p>Oversight Policy is evidenced. The Policy provided makes no mention to the reporting requirement levied on the Contractor nor does it include any of the state contractual language.</p> <p>The Annual Disclosure of Ownership information has been provided from each of CCKY's subcontractors.</p> <p><u>Recommendation for CCKY</u> The Oversight Policy should be updated to address disclosure of subcontractors to DMS.</p> <p>MCO Response: The Oversight Policy is on the Policies and Procedures agenda for an update to reflect the disclosure of subcontractors to DMS.</p>		<p>Subcontractor Monitoring reports for Q1 2014, Q2 2014, Q3 2014 and Q4 2014, which were submitted to KDMS to demonstrate disclosure of subcontractors.</p> <p>Coventry did not submit a revised oversight policy containing the contract language that Coventry informs the Department of any subcontractor that provides services which engages another subcontractor in the performance of any term of the contract which in one year exceeds the lesser of 25k or 5% of the subcontractor's operating expense.</p> <p><u>Recommendation for Coventry:</u> The Oversight Policy should be updated to address the regulatory language and disclosure of subcontractors to DMS.</p>	<p>Since IPRO recommended that the policy be updated in the previous three compliance reviews, an LOC /CAP maybe issued.</p> <p><u>MCO Response</u> The Oversight Policy will be updated to address the regulatory language and disclosure of subcontractors to DMS</p>
6.4 Remedies				
<p>Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.</p>				



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

Final Findings

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

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	0	0	1	0
Total Points	0	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			1.0	

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



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

Final Findings

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

Documents

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

Reports

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



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

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				
<u>Care Coordination</u> 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.				
<u>Care Management System</u> 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.				
<u>Care Plan</u> means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
<u>Case Management</u> 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.				
<u>Children with Special Health Care Needs</u> means Members who have or are at increased risk for chronic physical,				



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

Final Findings

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
<i>CHIPRA</i> 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.				
<i>Comprehensive Assessment</i> means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
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-2013			
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms	Full-2013		Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results)	



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

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
that may be utilized by the Contractor.				
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.	Full-2013			
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-2013			
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Full-2013			
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	Full-2013			



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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 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.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full-2013		Includes review results for Care Coordination and Complex Case Management files	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Full-2013		Includes review results for Care Coordination and Complex 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.	Non-Compliance - The plan submitted CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) P/P. This document outlines the procedures to ensure access to care coordination for all DCBS clients. The plan also submitted CM-010 (Access to Special Needs Providers) P/P which outlines procedures to ensure	Minimal	Addressed in Policy and Procedure CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services outlines the procedures for identification and management for DCBS clients. It states that the MCO Liaison will coordinate the needs of foster and adoption assistance members whether they are enrolled in the CM program, including, the MCO Liaison participating in "service plan monthly meetings" with DCBS to address needs of the member; providing guardians with information on the WIC program and general health concerns; and	<u>DMS Response</u> This element received Non-Compliance in 2013 and 2014 and a Minimal in 2015. All three years required a Corrective Action Plan. DMS has concerns.

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

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
	<p>appropriate and timely access to providers, particularly for Individuals with Special Health Care Needs (ISHCN).</p> <p>UM-017 (Monitoring of Over and Under Utilization) described how the plan will collect, review, analyze and report on utilization data to assess performance as well as the performance of network providers and how this performance impacts the quality of care and well being of members. This P/P is a general policy, and not specific to the DCBS population.</p> <p>After the last audit, the plan stated that they updated CM-011 to address noted deficiencies; however, this P/P still does not address deficiencies, nor did the plan provide evidence to show how they track, analyze, report, and develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.</p>		<p>referring guardians to available community resources. The Policy and Procedure states that Foster care members are considered ISHCN (as are adoption assistance members). Additionally, it states that the MCO liaison will work with the case manager for those who are enrolled in case management (CM) and that the Policy and Procedure for complex care management (CM-004) will be followed.</p> <p>Policy and Procedure CM-017 Case Management of Persons with Special Needs notes that although DCBS and DAIL clients are considered ISHCN, there are separate Policies and Procedures for those individuals (CM-011 and CM-012, respectively).</p> <p>During the onsite interview, Coventry provided a PowerPoint presentation and discussed care coordination for DCBS clients. Details of the presentation included: as of March 2015, ~4,700 DCBS (Foster/Guardianship) clients were enrolled; during Q2 & Q3 2014, outreach included 2,364 contacts to 624 members. The majority of contacts were for foster care/adoption coordination purposes (1,594 of 2,364, 67%); a total of 732 assessments for 599 members were</p>	<p align="center">  CM - 017 Case Management of Persc The presentation is not an official document and was not considered all-inclusive. Our policy is all-inclusive .This Policy CM=017 addresses this. </p>



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

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
	<p>In the interview, CCKY indicated that all grievances, UM activities, and concerns for the DCBS population are routed to the DCBS lead for management. This addresses the tracking and actions for individual DCBS members related to access to care and complaints and the like.</p> <p>CCKY provided a process for evaluating satisfaction of child members in foster care. This is a new process to be implemented so there are no data at present.</p> <p>However, the survey addresses satisfaction only - it does not address population-based measurement and analysis of utilization, access, complaints and grievances for the DCBS population.</p> <p><u>Care Coordination File Review</u> 10 files were reviewed. 8/10 included a comprehensive assessment and care plan; for the 2 remaining files – one opted out of care coordination and the</p>		<p>conducted for current and ongoing needs; a very small percentage was found to need acute or complex care management. Of 732 assessments, 53 (~7.2%) met criteria; of those, 43 opted-out and 10 were enrolled in CM. The presentation did not specifically detail the care coordination activities, i.e., referral/linkage to community resources, coordination with DCBS, foster parents, providers, BH authorizations.</p> <p>Regarding outreach to DCBS clients, data on the number/percentage of the total DCBS member population had outreach attempts, were contacted, and the outcome of the contacts would be informative. Coventry did provide a document, Foster Care Listing, for Q3 2014, which listed members and outreach efforts. The majority of the members were listed as “No HRA/No CM Outreach” and with a result of “Max Attempts”.</p> <p>Coventry differentiated case management as for an acute need. Regarding coordination, the presentation indicated that case management staff handles assessment, outreach, care coordination and referrals to community resources; Mental Health (MH) CM staff coordinates</p>	<p>DCBS does not provide direct contact information for foster children. MCO relies on the DCBS regional worker or case worker to let the MCO know if member wants or needs CM. If CM is indicated through claims identification. The DCBS Regional worker reaches out to the foster parent.</p>



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

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
	<p>other has no needs identified.</p> <p><u>Complex Case Management File Review</u> 10 of 10 files reviewed included a comprehensive assessment, care plan, identification of physical and behavioral health needs, and facilitation and coordination of services.</p> <p>Recommendation for CCKY CCKY should track specific population-based measures for analysis and comparison to other populations. Stratifying measures across the member populations would satisfy this requirement. CCKY could examine the rates for the KY performance measures related to ISCHN (access to PCPs, well child visits, etc.) and implement actions for improvement where warranted. Other measures could include: utilization of ED, inpatient, primary care, dental and other services to identify potential gaps on a population-level.</p> <p>MCO Response: The plan has</p>		<p>authorizations for inpatient and outpatient Behavioral Health (BH) care. The MCO stated that the CM program is transitioning to where MH case managers perform CM functions, rather than just UR functions. The MCO stated that cross-training between MH and physical health (PH) CM was occurring.</p> <p>None of the Policies and Procedures addressed tracking and analyzing indicators for the DCBS population. UM-017 Monitoring of Over and Under Utilization, describes how the MCO will collect, review, analyze and report on utilization data to assess performance; however, this is a general policy, and not specific to the DCBS population.</p> <p>The QI Program Description (QIPD), page 5, Objectives, notes that additional special emphasis is placed on disabled, women, infants, children, adolescents, young adults, and EPSDT; however, this does not specifically address the required metrics for the DCBS population as required by the Contract.</p> <p>The HEDIS EPSDT Work Plan did not contain any specific references to measurements or interventions specific to</p>	<p>Health Plan's and DMS' Responses and Plan of Action</p> <p>CM will collaborate with UM to update policy UM-017 in order to add specific language for foster care and ISHCN's. Vicki Meska said that the bed days report is part of what IPRO is seeking. The policy should also specifically include the DCBS/DAIL population. MCO sends a report monthly and quarterly to all regional MCO liaisons and DCBS management detailing the number of service plan reviews conducted for guardianship, foster and adoption assistance member outcome decisions, such as referral to case management and rationale for decisions. This report also includes claims, but it is not considered a report on utilization.</p> <p>CM is not responsible for the HEDIS EPSDT workplan. The 411 report and EPSDT is a standard report for all MCOs and no data</p>



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

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
	<p>created a specific population based measure for analysis and comparison to other populations. These measures will allow CoventryCares of KY to confirm access to coordination of care for all DCBS clients. Eligible populations will be identified for both ISHCN members, and a comparable population of members of similar age. Metrics for measures such as annual dental visits, well child visits, adolescent well care and access to PCP's will be tracked for both groups.</p> <p>Secondly, these measures will be compared between the ISHCN and overall populations. A statistical T-test for variation of means will be performed using the sample sizes for each measure. In instances where the ISHCN population shows a statistically significant decrease (at the 95% confidence interval level) in care coordination than the population at large, plans for corrective action will be created to address the discrepancy in</p>		<p>the foster population.</p> <p>Report #96 Audited HEDIS Reports provides HEDIS measures stratified by category of aid, gender and race; however, no comparisons or analysis are presented. The report also includes the Healthy Kentuckians (HK) measures. These rates are not stratified. The MCO reported the set of measures for ISHCN, but no comparisons or analysis were provided.</p> <p>The MCO provided Report#29 Grievances and Appeals for Q4 2014. This report had a general focus and did not specifically focus on DCBS clients.</p> <p>Coventry provided copies of 3 monthly corrective action plan (CAP) reports to DMS (utilization for children in foster care: well visits, hearing screens, immunizations, lead testing). Data for other months was not provided. The report contains comparisons between the ISHCN and rest of member populations for the following metrics: well visits, hearing tests, vaccinations, and lead testing. However, the specifications used to calculate the measures and the specific member age group(s) included were not clear. The MCO was asked for clarification but was</p>	<p>specific to foster care is required.</p>



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

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
	<p>care for ISHCN clients.</p> <p>For the “control” group population, we will select a large (>500) random set of members from the general population of enrollees who are between the ages of 12 months and 19 years of age as of December 31 of the measurement year. Metrics will be applied identically to this population and the ISHCN population.</p> <p>The ISHCN population will be defined as the child and adolescent enrollees, in the SSI and Foster categories of aid, and those who received services from the Commission for Children with Special Health Care Needs (CCSHCN), who received the specified services related to access to care and preventive care, as defined in the HEDIS specifications.</p> <p>The outline of the measurement procedure/steps is attached as KY PM 2014 ISCHN_Access_Preventive_Care_Final_Rev_7-10-2014.docx.</p>		<p>not able to provide it as the staff member who calculated the measures was not available.</p> <p>Coventry was to submit the following follow-up documents in response to the onsite review: data from grievances, UM and concerns for the DCBS population with evidence of aggregation and analysis and results for the satisfaction survey for children in foster care. A copy of a satisfaction survey form for complex care management was provided, but it did not relate to the foster care population.</p> <p><u>Recommendation for Coventry</u> Coventry should include a specific objective in the QIPD related to tracking, analyzing, reporting, and when indicated, developing and implementing corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.</p> <p>Coventry should include a task in the QI Work Plan for the above-mentioned objective.</p> <p>Coventry should stratify both HEDIS and HK measures across the member populations,</p>	<p>DCBS must provide the contact information for the DCBS population and all surveys will be mailed to foster care members participating in CM.</p> <p>CM/UM/QI/BH/PR/G&A: need to develop a work group on how to provide IPRO with a report specific to the DCBS population. This report to include bed days, access, complaints and grievances. This report should be completed as part of the corrective action plan. This is not a standard report that we are required by contract to submit. A documented process should be developed so that this report becomes standard report/documentation for all IPRO audits.</p>



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

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
			<p>compare the rates across the populations, analyze the information and develop and implement corrective actions when warranted.</p> <p>Coventry should do the same for measures related to utilization (e.g., Emergency Department (ED), inpatient, specialty care), complaints and grievances, and services specific to the DCBS population.</p> <p>Regarding outreach to DCBS clients, Coventry should track the number/percentage of the total DCBS member population that had outreach attempts, were contacted, and the outcome of the contacts.</p> <p>Coventry was to submit the following follow-up documents in response to the onsite review: data from grievances, UM and concerns for the DCBS population with evidence of aggregation and analysis and results for the satisfaction survey for children in foster care. A copy of a satisfaction survey form for complex care management was provided, but it did not relate to the foster care population.</p> <p><u>Final Review Determination</u> No change in review determination.</p>	<p>CM will need to develop a report specific for IPRO even though this is not a standard report required by the contract.</p>



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

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
			<p>Regarding the contract requirement: "The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients" and the MCO's responses:</p> <p>Coventry's Policy and Procedure CM-011 indicates that the MCO Liaison will coordinate the needs of foster and adoption assistance members whether they are enrolled in the CM program, by:</p> <ul style="list-style-type: none"> - Participating in "service plan monthly meetings" with DCBS. - Providing guardians with information on the WIC program and general health concerns and referring to available community resources. <p>It was understood that the case management presentation did not encompass all information on CM for DCBS clients; however, it was the most detailed information available for review related to care coordination activities for DCBS members. The document was considered "official" in that it was provided for purposes of the compliance review.</p> <p>Policy and Procedure CM-017 states that although DCBS and DAIL clients are</p>	



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

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
			<p>considered ISHCN, there are separate Policies and Procedures for those individuals (reference CM-011 and CM-012, respectively).</p> <p>The MCO is responsible for ongoing monitoring and care coordination of all enrolled members, especially those who are DCBS clients, regardless of whether the member's needs are managed primarily by DCBS and/or if there is no need for MCO case management. Additionally, all enrollees that are new to MCO should have a Health Risk Assessment conducted, including DCBS clients.</p> <p>Regarding the Contract requirement: "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" and the MCO's responses:</p> <p>The activity described above, specific to the DCBS population, is, in fact, a contract requirement, though it is not specifically listed as a regular "report" in the contract Appendix.</p>	



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

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
			<p>For the DCBS population, Coventry needs to measure, report, analyze, and develop and implement improvement strategies on indicators of utilization, access, complaints and grievances, and services that are specific to the DCBS population. Examples of possible metrics to use include, HEDIS and EPSDT/(CMS-416). Coventry can choose the specific measures, as long as each of the required categories is addressed. This is the MCO's contractual responsibility, regardless of which department fulfills the requirement.</p> <p>To demonstrate compliance with this requirement, Coventry indicated that results for a satisfaction survey for children in foster care would be provided. The MCO provided a copy of a complex care management satisfaction survey. If the MCO chooses to use this satisfaction survey to meet the requirement, the MCO should use the contact information in the CM file or obtain it from DCBS, if needed, so that satisfaction with CM can be reported for the DCBS population that is enrolled in CM.</p> <p>Coventry should make its existing report, "Foster Care Listing (Q3 2014)" more useful by including the number/percentage of the</p>	



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

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
			total DCBS member population that had outreach attempts, were contacted, and the outcome of the contacts. However, this is not a contract requirement.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.	Full-2013			
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-2013			
The Contractor shall have an internal operational process, in accordance with policy and procedure, to	Full-2013			



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

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
target Members for the purpose of screening and identifying ISHCN's.				
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.	Full-2013			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; individuals with chronic behavioral health illnesses; and children receiving EPSDT Special Services.	Full-2013		Includes review of MCO Report #20 Utilization of Subpopulations and ISHCN (see Quarterly Desk Audit results)	
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.	Full-2013			
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-2013			
The Contractor will produce a treatment plan for enrollees with special health care needs who are	Full-2013			



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
determined through assessment to need a course of treatment or regular care monitoring.				
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.	Full-2013			
35.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.	Substantial - Addressed in P/P CM-017. CCKY submitted the following reports: 1. Foster Care active as of 1-29-14 with ME codes.xlsx 2. Care coordination listing 7-1-13 thru 12-31-13 with codes.xlsx In the onsite interview, CCKY indicated that P/P FIN-001 Reporting Timeframes addresses monthly reporting of Foster Care Cases, specifically, Report #65 Foster Care and Report #66 Guardianship. <u>DCBS Service Plan File Review</u> IPRO conducted a review of DCBS	Minimal	Includes review results for DCBS Service Plans and DCBS Claims/Case Management files Addressed in Policies and Procedures CM-017 Case Management of Persons with Special Needs and CM-102 Case Management for Adult Guardianship address the requirements with the exception that neither document specifically states that addresses that the contractor shall be responsible for the ongoing care coordination for DCBS and Adult Guardianship clients whether or not enrolled in case management. Reports entitled "Master Foster List" for the months of July 2014 through February 2015 were provided. There were no reports for January 2014 through June	DMS Response In 2013 and 2015 this element received a Minimal and in 2014 a substantial. DMS has concerns CM-017 submitted for P&P review of revisions. Updating the other policy as well. This is because the MCO created a report specifically for the DCBS meetings held monthly. The report was created with input from DCBS. It was not available during the months IPRO



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>Services Plans. A total of 12 files were reviewed.</p> <p>4 of 12 had no DCBS signature 9 of 12 had no MCO signature 1 of 12 cases demonstrated use of the service plan to identify the member's medical needs and need for CM.</p> <p>10 of 12 cases demonstrated ongoing coordination of care with DCBS. There was documentation of many attempts by the CM to reach the DCBS worker.</p> <p>1 of 12 cases had documentation of need for and referral to CM. 8 of 12 cases demonstrated monthly meeting of CM/DCBS to coordinate and address the needs of the child.</p> <p>CCKY indicated that it was difficult to reach the DCBS workers in many cases and that the MCO DCBS liaison has been aggressive in efforts to obtain service plans. This has been particularly challenging due to the large number of service</p>		<p>2014. These were lists of the foster members with demographic information as well as whether a Service Plan had been received.</p> <p>Upon discussion with DMS, review of Service Plans is not applicable.</p> <p><u>DCBS Service Plan File Review Results</u> 5 of 12 files in the sample were provided (10 + 2 oversample). 3 of 5 had a Service Plan, 2 were dated in 2011 and 2013. 1 of 3 Service Plans was signed by both DCBS and MCO. 0 of 3 Service Plans were used for CM determination. 0 of 3 demonstrated ongoing care coordination; however, 2 were in long term placements. 3 of 5 were referred to CM, 2 were unable to determine. 0 of 3 referred were enrolled in CM. Therefore, 5 of 5 were not applicable for coordination with DCBS for developing and changing the care plan. 0 of 5 demonstrated monthly meetings with DCBS.</p> <p><u>DCBS Claims/Case Management files</u> For the 3 child members,</p>	<p>reports it missing. Service plans are reported to the state monthly and quarterly.</p> <p>Often times the services plans are incomplete and a determination for CM cannot be made because there is not enough information. MCO is unable to receive all services plans even though repeated attempts are made and this is discussed at every monthly meeting with DCBS. Service plan information is gathered by the state. Coordination of care, supportive services and case management services are dependent on the communication from the field workers. MCO outreach attempts should be accepted as compliant. MCO should not be held accountable for non-responsiveness of the DCBS field worker. Contact information for the foster parents is essential to completing health risk assessments.</p>



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

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
	<p>areas/counties and DCBS offices. Often service plans are sent to CCKY from DCBS, and therefore, there is no MCO signature on the Service Plan. CCKY provided meeting logs which evidenced regular meetings with DCBS.</p> <p>Files showed a lot of back and forth via voicemail for the MCO CM to reach the DCBS worker. The CM files were well-documented and showed evidence of ongoing identification of needs, referrals and linkage, care coordination, and follow-up where necessary.</p> <p><u>DCBS Claims File Review</u> IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination.</p> <p>The files did not contain claims data. CCKY did provide this via ftp posting. Claims were reviewed</p>		<p>0 of 3 had documentation of well visits or EPSDT Services. 0 of 3 had documentation of outreach for EPSDT services</p> <p>Since the file results may be difficult to interpret, a summary of each of the cases is below Case #1 – An adolescent resident in residential placement. Service Plan was dated from 2011. No updates were seen. Attempts to reach DCBS worker were not successful. The member was screened but found not appropriate for CM due to BH condition and residential placement. There was no evidence that the member was followed or status updated (attempted or done). At a minimum, an annual update would be expected. Would expect at least once annual status update. No EPSDT services or outreach documented.</p> <p>Case #2 – Child/toddler-aged member termed during Q1 2015. No Service Plan was found. Note dated in 2014 states "Email sent/received" with no further detail. No EPSDT services or outreach documented.</p> <p>Case #3 Adult guardianship client. Service plan was signed by guardian as Power of</p>	<p>Current contractual requirements specifically state duplication of services is prohibited. Members in residential placement or long-term care do not receive case management services because they are already receiving care and services from the facility. Upon discharge the CM discharge planner is notified and at that time the member is provided outreach, coordination of care and case management services if indicated.</p> <p>Service plans already addressed.</p> <p>MCO's do not sign service plans as these are proprietary to the state.</p>



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>offsite after the onsite review.</p> <p>Ten files were reviewed with the following results: 9 of 10 files included evidence of at least one well visit during the review period. 9 of 10 files evidenced EPSDT services provided. 1 of 1 file evidenced outreach for lack of EPSDT services. 3 of 3 files evidenced coordination of PH and BH services. 10 of 10 files showed coordination between providers and services.</p> <p>For the one member who did not have any well visits or EPSDT services, the CM noted a history of non-compliance and did conduct outreach for EPSDT services.</p> <p>Of note: CCKY has developed and is using an excellent tracking sheet which includes: Program Status, Category Code, medically fragile, date of contact initiation, number</p>		<p>Attorney (POA). No space on the form for MCO signature. The member was placed in a long term facility. No attempts to contact DAIL/guardian and no meetings were documented. EPSDT not applicable – adult.</p> <p>Case #4 – Child/school-aged member termed 12/31/14. No Service Plan was found. The member was referred for ECM, but did not meet criteria. A note dated in 2014 states “Email sent/received” with no further detail. No meetings with DCBS were documented. No EPSDT services or outreach documented.</p> <p>Case #5 – Adult guardianship client. The Service Plan was dated 2013, signed by DAIL, with no space for the MCO signature. No updates were seen. A 2012 communication with the member’s guardian in 2012 indicates “no CM needs. The member is living in a Personal Care Home (PCH), will contact if needed.” Referred to CM but not enrolled. No meetings with DAIL were documented, would expect an annual status update at a minimum. EPSDT services not applicable – adult.</p> <p>Regarding working with DCBS/DAIL to obtain Service Plans, Coventry provided a</p>	<p>DAIL members have no contact information, as it is not provided by the state. No case management services for long-term care members if in greater than 30 days.</p> <p>Meeting dates were submitted. Already addressed services plans. Will elaborate on emails sent/received with further detail. Staff training.</p> <p>Same as above</p>



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>of attempts to contact DCBS, permission from DCBS to contact foster parent, screening tool completed, acute needs addressed, benefits questions addressed, referrals/resources provided, mailed information sent, therapies, need for coordination of therapies during school breaks, enrollment in First Steps or CM, member not enrolled in CM/case closed, member not enrolled in CM/follow-up call scheduled, ESPDT special services, reason member not enrolled in CM, conference calls, incoming calls from DCBS/foster parent.</p> <p><u>Recommendation for CCKY</u> CCKY should continue its efforts to obtain Service Plans and to meet with DMS and DCBS staff to establish effective information-sharing protocols.</p> <p>MCO Response: The plan will continue to communicate and meet with DCBS on a regular basis. Each month the plan attends the Liaison Meetings</p>		<p>document, Master Foster List March 2015, which contained information for all enrolled DCBS clients. The document revealed that of the 4,000+ members, ~1106 had Service Plans, ~2702 did not have Service Plans, and for ~992 there was no information (blank). The MCO also provided a PowerPoint presentation that indicated reports of missing Service Plans are sent to each region every month. Additionally, During the onsite interview, the MCO indicated that some of the regional liaisons were difficult to reach and that many had changed recently so it was hoped more successful contact could be made.</p> <p><u>Recommendation for Coventry</u> Coventry should address the Contract language in its Policies and Procedures "the Contractor shall be responsible for the ongoing care coordination clients, whether or not enrolled in case management".</p> <p>Coventry should develop and implement a process for ongoing care coordination for all DCBS/DAIL clients, regardless of enrollment in CM.</p> <p>Coventry should ensure that the required reports of DCBS/DAIL clients are submitted</p>	<p>The policy was updated to include this information. Ongoing care coordination is provided regardless of enrollment in the CM program. CM-011 is compliant</p>



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>with delegates from DCBS, DMS, CRP, and MHNET to address concerns as illustrated below.</p> <p>Dates of Liaison Meetings and agenda items covered during the First Quarter 2014:</p> <ul style="list-style-type: none"> 01/23/2014 (Telephonic) In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues 02/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet 		<p>for each month.</p> <p>Coventry should continue and strengthen efforts to obtain Service Plans with more direct outreach to DCBS liaisons. The MCO did not provide notes, logs or minutes for the meetings with DCBS.</p> <p>Coventry should ensure that discussion of all DCBS/DAIL clients is documented in monthly meetings with DCBS, regardless of enrollment in CM or not.</p> <p>Coventry should ensure that status updates are performed at regular intervals (annually at a minimum) for DCBS/DAIL clients in long term residential placements.</p> <p>Coventry should ensure that all DCBS clients are monitored for receipt of well care and EPSDT services and if gaps are identified, outreach and other actions to promote the receipt of missing services are conducted.</p> <p>Final Review Determination No change in review determination.</p> <p>The review determination is based on the file review results related to documentation of care coordination,</p>	<p>Minutes will capture member names moving forward.</p> <p>The DCBS workers have always had a placement for the child and follow up out patient therapy or residential placement. MCO asks DCBS worker if the member is in foster care if the foster parents need support, because the DCBS worker has to agree to that and contact the foster parents first. More often than not, the DCBS worker does not return 3 attempts with verifiable VM's. A follow up letter is sent with contact info.</p> <p>MCO already performs care coordination for foster members whether or not they are enrolled as referenced in CM-011. CM policy CM-017 will be updated to say care coordination will be performed on members enrolled or not enrolled in CM.</p>

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

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
	<p>Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues</p> <ul style="list-style-type: none"> 03/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet 04/24/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet <p>Discussed: Foster Care Service Plans, Satisfaction Surveys, Barriers to Assisting Members, Discharge Planning and individual member issues</p> <p>Discussed: Foster Care Service Plans, Supports to</p>		<p>monthly meetings with DCBS and receipt of and follow-up for well care visits and EPSDT services for DCBS/DAIL clients, where applicable.</p> <p>Although DMS has indicated that review of Service Plans and signatures on Service Plans is not applicable for review, according to DMS, the MCOs remain responsible for coordination of care for DCBS members whether or not enrolled in the MCO's care management program and despite that DCBS is the primary care manager. Additionally, the MCOs remain responsible for ongoing coordination and monthly meetings for all DCBS members.</p> <p>Regarding the MCO responses to the File Review results: Coordination of care and supportive services remain the MCO's responsibility and, at a minimum, full and clear documentation for each member of attempts to outreach and coordinate with DCBS is expected for all DCBS members. If contact is unsuccessful, there should be documentation of efforts for all members via the monthly meetings.</p> <p>While CMS-416/EPSTDT reporting is not a CM activity, the MCO is responsible for</p>	<p>Contract Section 37.1 states; a quarterly report be submitted detailing the number of service plans.</p> <p>All minutes from the DCBS meetings were provided.</p> <p>Members enrolled and not enrolled in CM are discussed at monthly meetings with DCBS. Policy CM-017 will be updated to state members enrolled or not enrolled in CM will be discussed at monthly DCBS meetings. CM-011 DOES state coordination of care is done regardless of CM enrollment status. See highlighted area on policy.</p> <p style="text-align: center;"></p> <p>CM - 011 Members in Foster Care and Adop</p>



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

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
	<p>Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues</p> <ul style="list-style-type: none"> • 05/22/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues • June meeting was cancelled per the state. 		<p>ensuring that its DCBS members receive routine PCP visits and EPSDT services and should monitor and track this and make outreach attempts when necessary, as is required by the contract.</p> <p>Per discussion with DMS, provision of care coordination for DCBS and DAIL clients enrolled in the MCO is not considered a duplication of services. If a member's care is being managed by DCBS/DAIL, a facility or another agency, the MCO remains responsible. Per the contract, "The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services."</p> <p>Regarding members in long term care for greater than 30 days, DMS indicated that the MCO remains responsible for following the status of these members.</p> <p>Regarding DAIL members, specifically: Per DMS, DAIL members' contact information is available, and in fact, Coventry currently submits a DAIL report to DMS that includes this information. Note that Policy CM-012 indicates that the</p>	



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

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
			<p>DAIL member will be outreached and assessed by the MCO CM once the contact information is obtained.</p> <p>Regarding DCBS meeting minutes, these were not found in the MCO's document submissions.</p> <p>Regarding the Policies and Procedures, CM-017 and CM-012 were noted as not containing the contract language regarding ongoing care coordination. CM-011 was noted as compliant in the prior element.</p> <p>Additionally, the MCO needs to ensure both that the Policies are compliant with the contract language and compliance with ongoing care coordination is demonstrated via member-specific documentation.</p>	
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			



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

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
35.4 Children in Foster Care				
<p>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.</p>	<p>Substantial - Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs). As noted above, CCKY makes diligent efforts to obtain Service Plans for all foster children who are members. CCKY provided logs to demonstrate regular meetings with DCBS. See element 35.2 above for detailed information.</p> <p><u>DCBS Service Plan File Review</u> 4 of 12 had no DCBS signature 9 of 12 had no MCO signature 1 of 12 cases demonstrated use of the service plan to identify the member's medical needs and need for CM. See element 35.2 above for further detail.</p> <p><u>Recommendation for CCKY</u> CCKY should continue its efforts to obtain Service Plans and meet with and coordinate with DMS</p>	Minimal	<p>Includes review results for DCBS Service Plans files.</p> <p>Addressed in Policy and Procedure CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services and CM-017 Case Management of Persons with Special Needs.</p> <p>Coventry provided descriptions of the DCBS meetings held between January and May 2014. The notes, minutes, or logs were not provided. Therefore, it cannot be determined which specific members were discussed at each of the meetings, regarding Service Plans and/or other issues. Since there are a total of 4,000+ DCBS clients enrolled and MCO reports indicate that ~2702 do not have Service Plans; it is not clear how each member could have been addressed in those 5 meetings.</p> <p>Coventry did provide a document, Foster Care Listing, for Q3 2014, which listed members and outreach efforts. The majority of the members were listed as "No HRA/No CM Outreach" and with a result of "Max Attempts".</p>	<p>DMS Response In 2014 this element received a substantial and in 2013 and 2015 has received a minimal and DMS does have concerns.</p> <p>Members are addressed on the monthly list, but they are not individually discussed unless there are issues requiring intervention. DCBS told us that we are the only MCO who provides them with such detailed information and they are pleased with our performance.</p> <p>HRA's were addressed above.</p>



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>and DCBS staff.</p> <p>MCO Response: See response above.</p>		<p>Upon discussion with DMS, review of Service Plans is not applicable.</p> <p><u>DCBS Service Plan File Review Results</u> 5 of 12 (10 +2 oversample) requested files were provided. 3 of 5 had a Service Plan, 2 were dated in 2011 and 2013. 1 of 3 Service Plans was signed by both DCBS and MCO 0 of 3 Service Plans were used for CM determination 0 of 3 demonstrated ongoing care coordination; however, 2 were in long term placements. 3 of 5 were referred to CM, 2 were unable to determine. 0 of 3 referred were enrolled in CM. Therefore, 5 of 5 were not applicable for coordination with DCBS for developing and changing the care plan. 0 of 5 demonstrated monthly meetings with DCBS. See element 35.2 above for further detail.</p> <p><u>Recommendation for Coventry</u> See above element 35.2</p> <p><u>Final Review Determination</u> No change in review determination.</p>	<p>Service plans were addressed above.</p>



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

Final Findings

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
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
			<p>The review determination is based on the file review results for documentation of monthly meetings with DCBS for the specific members.</p> <p>No minutes for the DCBS monthly meetings were found in the MCO's document submissions.</p>	
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.	<p>Substantial - Partially addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services).</p> <p>P/P documents do not address cases where the DCBS and CM staff cannot reach an agreement on the service plan for a</p>	Minimal Not Applicable	<p>Includes review results for DCBS Service Plans files</p> <p>Addressed in P/P CM-011 Case Management for Members in Foster Care and Members Receiving Adoption Services</p> <p>Upon discussion with DMS, review of Service Plans is not applicable.</p>	<p><u>DMS Response</u></p> <p>In 2014 this element received a substantial and in 2013 and 2015 has received a minimal and DMS does have concerns.</p>



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

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
<p>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.</p>	<p>Member, i.e. that the case will be forwarded to the designated county DCBS worker, that the case might be referred to mediation or DMS for resolution.</p> <p>In the interview, CCKY indicated that P/P CM-011 would be updated to address situations where CCKY and DCBS cannot reach an agreement on the Service Plan/CM enrollment.</p> <p><u>DCBS Service Plan File Review</u> IPRO conducted a review of DCBS Services Plans. A total of 12 files were reviewed. 4 of 12 had no DCBS signature 9 of 12 had no MCO signature</p> <p>As indicated prior, CCKY has a designated DCBS liaison, is diligent in efforts to obtain Service Plans, and has arranged to meet regularly with DCBS staff.</p> <p>If a Service Plan is received in other than a DCBS/CCKY meeting, it will not have an MCO signature.</p>		<p><u>DCBS Service Plan File Review Results</u> 5 of 12 (10 +2 oversample) requested files were provided. 3 of 5 had a Service Plan, 2 were dated in 2011 and 2013. 1 of 3 Service Plans was signed by both DCBS and MCO 0 of 3 Service Plans were used for CM determination See element 35.2 above for further detail.</p> <p><u>Recommendation for Coventry</u> See above element 35.2</p>	



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

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
	<p><u>Recommendation for CCKY</u> P/P CM-011 should be updated to address situations where CCKY and DCBS cannot reach an agreement on the Service Plan/CM enrollment.</p> <p>MCO Response: The following language has been added to CM-011 and sent for review to the Policy and Procedure Committee for approval:</p> <p>If the DCBS staff and the plans Foster Care/Subsidized Adoption Case Manager Liaison 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 staff and Foster Care/Subsidized Adoption Case Manager Liaison will be forwarded to the designated county DCBS worker.</p> <p>The DCBS staff member shall work with the plans Foster</p>			



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

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/Subsidized Adoption Case Manager Liaison and a designated Department representative, if needed, to agree on a service plan. If the agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.			
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.	Full-2013			
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.				
Preventive and remedial services as contained in 907	Full-2014			



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

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
KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.				
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.	New Requirement	Non-Compliance	<p>No Policy and Procedure for Pediatric Interface Services was found. No document addressing hospice/palliative services was found.</p> <p>The Member Handbook addresses hospice services as a covered service on page 32. This was the only reference to hospice and/or palliative services that was found.</p> <p>During the onsite interview, documents to address this were requested. The MCO did not provide any follow-up documents.</p> <p><u>Recommendation for Coventry</u></p>	This references a contract that was not in effect during the audit period. Pediatric interface is utilization management/prior authorization of services. Pediatric interface is not a case management function.



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

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
			<p>Coventry should develop a new Policy and Procedure or revise an existing Policy and Procedure to address this requirement.</p> <p><u>Final Review Determination</u> No change in review determination.</p> <p>Per discussion with DMS, the ACA Pediatric Interface requirement for pediatric concurrent care, palliative hospice services, curative services and medications was a Contract requirement during the period of review.</p> <p>Additionally, regardless of whether Pediatric interface is a case management function, this is the MCO's contractual responsibility, and compliance is required.</p>	
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-2013		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: CoventryCares of Kentucky

Final Findings
Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	0	0	3	1
Total Points	0	0	3	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				0.75

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



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

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: CoventryCares of Kentucky

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.	Full-2013			
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.	<p>Substantial - Member rights and responsibilities are included in the Provider Manual and are available on the MCO website. A policy/procedure for describing the MCO's method for communicating this information to out of network providers was not evident in the documents provided.</p> <p>Onsite: CCKY noted that the provider manual is available on the MCO website to out of network providers.</p> <p><u>Recommendation for CCKY</u> The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.</p> <p>MCO Response: The contract language specifically requires CCKY to provide member rights and</p>	Substantial	<p>Member rights and responsibilities are communicated to members in the Member Handbook, Section 2 Rights and Responsibilities, pages 9 – 11; to network providers in the Provider Manual, Section 4 Member Services and Benefits, pages 42-43; and via the website, which is publicly available. Out-of-network providers may access the information on the website and Coventry stated that the information is provided to those providers on request.</p> <p>However, the MCO does not currently have a policy/procedure that addresses how member rights and responsibilities are shared with network providers, members and specifically, out of network providers.</p> <p>Upon discussion onsite, it was agreed that in order to resolve this requirement, Coventry could add the following to its policy/procedure RR-002 Member Rights and Responsibilities:</p> <ul style="list-style-type: none"> - Members are informed via the 	<p><u>DMS Response</u> Since IPRO recommended that the policy be updated in the previous year also, an LOC /CAP maybe issued.</p> <p><u>MCO Response</u> Coventry will add the following to its policy/procedure RR-002 Member Rights and Responsibilities:</p> <ul style="list-style-type: none"> - Members are informed via the Member Handbook. - Network providers are informed via the Provider Manual. - Out-of-network providers are informed via the website and upon request. - This information is communicated publicly via the website.



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	responsibilities policies to any Out-of-Network Provider upon request from the provider. Any requests received by a provider, by any means, including through the Provider Call Center, is provided to them and providers are referred to the MCO website where it is easily accessible.		Member Handbook. - Network providers are informed via the Provider Manual. - Out-of-network providers are informed via the website and upon request. - This information is communicated publicly via the website. <u>Recommendation for Coventry</u> Coventry should revise policy as agreed.	
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Full-2013			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Full-2013			
C. Consent for or refusal of treatment and active participation in decision choices;	Full-2013			
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Full-2013			
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;	Full-2013			
F. Timely access to care that does not have any	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
communication or physical access barriers;				
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Full-2013			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Full-2013			
I. Timely referral and access to medically indicated specialty care; and	Full-2013			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Full-2013			
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Full-2013			
B. Abide by the Contractor's and Department's policies and procedures;	Full-2013			
C. Become informed about service and treatment options;	Full-2013			
D. Actively participate in personal health and care decisions, practice healthy life styles;	Full-2013			
E. Report suspected Fraud and Abuse; and	Full-2013			
F. Keep appointments or call to cancel.	Full-2013			
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)	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.				
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.	Full-2013			
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full-2013			
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	Full-2013			
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Full-2013			
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephone numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;	Full-2013			
B. The procedures for selecting a PCP and scheduling an initial health appointment;	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;	Full-2013			
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-2013			
E. Member rights and responsibilities including reporting suspected fraud and abuse;	Full-2013			
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Full-2013			
G. Procedures for obtaining transportation for both emergency and non-emergency situations;	Full-2013			
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Full-2013			
I. Procedures for arranging EPSDT for persons under the age of 21 years;	Full-2013			
J. Procedures for obtaining access to Long Term Care Services;	Full-2013			
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
L. A list of direct access services that may be accessed without the authorization of a PCP;	Full-2013			
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-2013			
N. Information about how to access care before a PCP is assigned or chosen;	Full-2013			
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-2013			
P. Procedures for obtaining Covered Services from non-network providers;	Full-2013			
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;	Full-2013			
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Full-2013			
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Full-2013			
T. Information on the availability of health education services;	Full-2013			
U. Information deemed mandatory by the Department; and	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
V. The availability of care coordination, case management and disease management provided by the Contractor.	Full-2013			
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-2013			
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 lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
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	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).				
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.	Full-2013		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 Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.	Full-2013			
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	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.				
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	<p>Non-Compliance - Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p>Recommendation for CCKY Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p> <p>MCO Response: As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.</p>	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
B. Monitoring the selection and assignment process of	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-	



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
PCPs;			Member Services; dated 12/17/14.	
C. Identifying, investigating, and resolving Member Grievances about health care services;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
D. Assisting Members with filing formal Appeals regarding plan determinations;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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);	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
I. Explaining or answering any questions regarding the Member Handbook;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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 termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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.	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
O. Facilitating access to behavioral health services and pharmaceutical services;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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 Shriners' Hospital for Children;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
T. Facilitating access to Member Health Education Programs;	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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 them including referral to case management or disease management; and	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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.	Non-Compliance – See above.	Full	This requirement is addressed in MC-008-Member Services; dated 12/17/14.	
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,	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.				
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-2013			
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-2013			
The Contractor shall have two processes in place for Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.	Full-2013			
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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-2013			
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-2013			
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-2013			
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Enrollee Rights
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.	Full-2013			
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-2013			
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-2013			



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

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	22	1	0	0
Total Points	66	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		2.96		

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



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

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: CoventryCares of Kentucky

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				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Full-2013			
Creative methods should be used to reach Contractor's Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.	Full-2013			
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Full-2013			
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-2013			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Full-2013			



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

Final Findings

Enrollee Rights and Protection: Member Education and Outreach
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.	Full-2013			
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-2013			
be published in at least a 14-point font size, and	Full-2013			
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full-2013			
Font size requirements shall not apply to Member Identification Cards.	Full-2013			
Braille and audiotapes shall be available for the partially blind and blind.	Full-2013			
Provisions to review written materials for the illiterate shall be available.	Full-2013			
Telecommunication devices for the deaf shall be available.	Full-2013			
Language translation shall be available if five (5) percent of the population in any county has a native language	Full-2013			



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

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
other than English.				
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.	Full-2013			
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.	Full-2013			
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 Coventry 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-2013			



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

Final Findings

Enrollee Rights and Protection: Member Education and Outreach <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall communicate such policies to Subcontractors.	Full-2013			



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

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	<i><u>Only 1 element scored and is Not Applicable</u></i>			
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	<i><u>Only 1 element scored and is Not Applicable</u></i>			

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



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

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



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

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				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.	Full-2013			
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-2013			
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Full-2013			
The Contractor shall include provisions in	Full-2014			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
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.				
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.	Full-2013			
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental	Full-2013			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
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-2013			
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Full-2013			
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and	Full-2013			
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-2013			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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-2013			
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:	Full-2013			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
A. Member/patient identification information, on each page;	Full-2013			
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;	Full-2013			
C. Date of data entry and date of encounter;	Full-2013			
D. Provider identification by name;	Full-2013			
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Full-2013			
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);	Full-2013			
G. Identification of current problems;	Full-2013			
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering	Full-2013			



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

Final Findings

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



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
<p>A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;</p>	<p>Substantial - The Provider Manual states that the CCKY Providers are responsible for maintaining records according to the state and federal requirements. Specifically it is addressed in the section on Medical Record Documentation Standards.</p> <p>As noted last year, the medical record documentation audit tool states "identification of current problems, significant illnesses, and medical/psychological condition should be indicated on the Problem List/or progress note." Physical examination is not included in the tool.</p> <p>Recommendation for CCKY Provider Manual, audit tool and guidelines in P/P #QI-015 (Medical Record Documentation Review) should be consistent and include all required elements in the contract.</p> <p>MCO Response: The medical record documentation audit for 2014 has been completed. The medical documentation tool will be updated to reflect this change and will be implemented to capture the physical examination requirements outlined for this recommendation- to be effective for the 2015 audit.</p>	<p>Full</p>	<p>QI-015 Medical Record Documentation Review, Attachment 1, Guidelines For Medical Record Documentation and the Provider Manual on page 14 address this requirement.</p>	
<p>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</p>	<p>Full-2013</p>			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
<p>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.</p>	<p>Substantial - This is addressed in the Provider Manual in the section on Medical Record Documentation Standards.</p> <p>As noted last year, the medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen. Follow-up plans are addressed.</p> <p><u>Recommendation for CCKY</u> Provider Manual, audit tool and guidelines in P/P #QI-015 (Medical Record Documentation Review) should be consistent and include all required elements in the contract.</p> <p>MCO Response: The medical record documentation audit for 2014 has been completed. The medical documentation tool will be updated to reflect this change and will be implemented to capture the medication requirements outlined for this recommendation- to be effective for the 2015 audit.</p>	Full	<p>QI-015 Medical Record Documentation Review, Attachment 1, Guidelines For Medical Record Documentation and the Provider Manual on page 14 address this requirement.</p>	
27.7/27.8 Advance Medical Directives				
<p>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</p>	Full-2013			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.				
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.	Full-2013			
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.	Full-2013			
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	Full-2013			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.				
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.	Full-2013			
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Full-2013			
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	Full-2013			



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

Final Findings

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
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
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.				
40.15 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract 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.	Full-2013			



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

Final Findings

Medical Records

Scoring Grid:

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

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

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: CoventryCares of Kentucky

Final Findings

Behavioral Health Services <i>(See Final Page for Suggested Evidence)</i>				
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				
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-2013			
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-2013			
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 DSM-V classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-V.	Full-2013			
Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record.	Full-2013			
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	Full-2013			



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

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
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.				
The Contractor shall utilize ICD-9/10 coding and DSM-V classification for Behavioral Health billings.	Full-2013			
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.	Full-2013			
Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.	<p>Substantial - Addressed in Geo Access reports. All counties were compliant with the exception of:</p> <p>1 Provider within 30 miles Fulton County, 55.8% for urban Livingston County, 96.9% for urban Meade County, 90.5% for urban</p> <p>1 Provider within 30 minutes Henderson County 99.6% for urban Ballard County 92.4% for urban Fulton County 50.2% for urban Hancock County 40.8% for urban Henderson County 99.6% for urban Livingston County 87.4% for urban Meade County, 79.4% for urban Trigg County, 99.6% for urban Breckinridge County, 96.8% for rural</p> <p>CCKY clarified that 100% of CMHCs had been</p>	Full	<p>This requirement is addressed in the MHNNet Network Access Analysis for determining appropriate accessibility.</p> <p>The MHNNet Behavioral Health Provider Quick Reference Guide on pages 9-10 and Global Capitation Network Participation Agreement between MHNNet and CoventryCares on pages 2, 9 and 49 address this requirement.</p> <p>During the onsite interview, it was verified that all available CMHC's are being utilized in the service region and telehealth services are available in rural areas.</p>	



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

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
	<p>offered network participation and all accepted.</p> <p>In the interview, CCKY/MHNet acknowledged that there are some gaps in some counties. The MCO added that starting in 2014, any licensed provider, e.g., psychologists, may participate in the BH network and this will help with access. CCKY/MHNet stated that 156 providers had been added to the network.</p> <p><u>Recommendation for CCKY</u> CCKY/MHNet should continue to recruit providers and re-assess the Geo-Access.</p> <p>MCO Response: 100% of the CMHCs in the Commonwealth of Kentucky are participating providers with MHNet and have been since go live on Nov. 1. 2011. All available CMHC's are being utilized. CCKY will continue to recruit providers and will continue to comply with the requirements of the Geo Access reporting.</p>			
To the extent that non-psychiatrists and other providers of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Full-2013			
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Substantial - Addressed in Geo Access reports. As noted above, access is expected to improve	Full	This requirement is addressed in the MHNet Network Access Analysis for	



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

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
	<p>due to the opening of the network to additional types of BH providers.</p> <p>Accessibility is addressed in these reports; however, provider availability is not measured. In the interview, CCKY/MHNet indicated that appointment availability surveys for the Kentucky market had been initiated and provided the telephone script.</p> <p>Recommendation for CCKY CCKY/MHNet should evaluate the results of the availability survey when available and take action where necessary.</p> <p>MCO Response: Starting in January 2014, CCKY began monthly surveys of the Kentucky providers. This survey addresses appointment availability, and seeks to confirm address/phone, specialties/ages served and languages spoken. This information is reported monthly on KY Report 118.</p>		<p>determining appropriate accessibility.</p> <p>Mechanisms used to measure provider availability are addressed in 07 Provider Availability survey information and MCO Report #118.</p> <p>Network adequacy and availability is addressed on pages 2, 9 and 49 of the Global Capitation Network Participation Agreement between MHNet and CoventryCares.</p>	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.	Full-2013			
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-2013			



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

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
33.6 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-2013			
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Full-2013			
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Full-2013			
It is not acceptable for an intake line to be answered by an answering machine.	Full-2013			
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:	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
B. No incoming calls receive a busy signal;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	



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

Final Findings

Behavioral Health Services <i>(See Final Page for Suggested Evidence)</i>				
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
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
D. The call abandonment rate is seven percent (7%) or less;	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
E. The average hold time is two (2) minutes or less; and	Full-2013		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.	Full-2013			
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.	Full-2013			
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	Full-2014			
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Full-2013			
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	Full-2013			



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

Final Findings

Behavioral Health Services <i>(See Final Page for Suggested Evidence)</i>				
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
Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.				
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full-2013			
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full-2013		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-2013			



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

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.	<p>Substantial - Addressed in MHNet UM Manual, Provider Quick Reference Guide and PCP Newsletter 2013.</p> <p>CCKY has in place a strong PH/BH mutual referral system with specific forms to be completed.</p> <p><u>BH/PH Care Coordination File Review</u> 10 files were reviewed 2 of 5 files evidenced a comprehensive assessment with the required components 2 of 5 files evidenced a care plan with the required components 4 of 9 files evidenced identification of the PH and BH needs of the member and facilitation and coordination of needed services 0 of 8 files evidenced follow-up/rescheduling of missed appointments 0 of 5 files for hospitalized members evidenced participation in discharge planning 0 of 10 files evidenced information sharing, other than the initial referrals from/to BH CM.</p>	Substantial	<p>Includes BH/PH Care Coordination file review summary results</p> <p>The Provider Newsletter First Quarter 2014 on page 5 addresses this requirement.</p> <p>The MHNet Contract on page 4 states that the practitioner agrees to comply with state and federal regulations and MHNet's policies, including, but not limited to, those pertaining to continuity and quality of care, medical management, etc.</p> <p>The MHNet Behavioral Health Provider Quick Reference Guide on pages 8 and 13 address this requirement.</p> <p>The MHNet Utilization Improvement Manual on pages 6-7 and 205 address this requirement. On pages 113-114, Chapter 5 Managing Ongoing Care</p>	



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

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
	<p>Note the following:</p> <p>Assessment - Many members were unable to contact, however, some information was available from the PH referral form. The 2 assessments that were present were narrative/informal assessments but were very detailed.</p> <p>Care Plan - Many members were unable to contact. The 2 care plans that were present were narrative and informal but communicated a clear plan for the member as far as referrals and resources.</p> <p>Identify and Address Needs - The referral forms from PH to MHNnet often contained background information on the member's PH and BH condition(s) as well as needs. As noted above, where a care plan was present, a clear plan was communicated.</p> <p>Missed appointments rescheduled – scheduled appointments were evident in many of the records in the notes or an authorization letter in the file. However, there was no documentation of follow-up to determine if the member kept the appointment.</p> <p>Discharge Planning - For the members who had an inpatient MH stay, participation in discharge planning was not seen in the files. In one case there is a notation of a "30 day plan" but details are not included.</p> <p>Information Sharing - Many cases ended after one outreach attempt with UTC and a letter sent or CM spoke with member with no further</p>		<p>provides the procedure for initiating behavioral health care management. This includes at least 2 phone attempts at different hours of the day, mailed letter, call attempt 10 days after the letter, and efforts to obtain alternate member contact information from providers, and health plan care manager.</p> <p>CoventryCares Provider Manual on page 22 states that PCP's responsibilities include: to provide, coordinate and/or direct all health care needs of members to maintain continuity of care. Additionally, on page 49 it states that PCPs can also contact MHNnet for assistance in facilitating specialty behavioral health services for members. MHNnet will assist members and PCPs with provider referrals and with making appointments for members in need of therapy and/or psychiatry services.</p> <p><u>BH/PH Care Coordination File Review Results</u> 10 files were reviewed. 7 of 10 files included a comprehensive assessment with the required components. The remaining 3 files were not applicable as the member was unreachable or refused services.</p>	



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

Final Findings

Behavioral Health Services <i>(See Final Page for Suggested Evidence)</i>				
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
	<p>documented outreach conducted.</p> <p>It is important to note that in the interview, CCKY/MHNet indicated that the 30 day plan is a discharge plan for inpatient follow-up for the first 30 days post-discharge and was not included in the files for review. A sample was provided onsite.</p> <p>MHNet P/P Utilization Improvement Manual regarding discharge planning and follow-up were provided by CCKY/MHNet onsite.</p> <p>P/P Chapter 6 Discharge Planning and Follow-up includes (section 6.1) initiating discharge planning, arranging follow-up care, and documentation; (section 6.2) contact after discharge, assessment/provision of resources, procedure for UTC: at least 2 phone attempts, letter, and follow-up in 10 days with an additional phone attempt as well as sending an appointment reminder letter on discharge, contact with the provider(s) to confirm that the appointment was kept, and procedure for rescheduling and/or other follow-up if the appointment is not kept.</p> <p>P/P Chapter 4 National Service Center Utilization Improvement which states that when a CM makes a referral to a provider, the CM will contact the provider to ensure that an appointment can be made, ask the provider to</p>		<p>5 of 10 files included a care plan with the required components. The remaining 5 files were not applicable.</p> <p>6 of 10 files included identification of the PH and BH needs of the member and facilitation and coordination of needed services; the remaining files were not applicable.</p> <p>1 of 10 files showed need for follow-up/rescheduling of missed appointments and follow-up was documented.</p> <p>2 of 10 members were hospitalized and participation in discharge planning was evident in one file. The second file was a member that had been hospitalized from 3/6/14-3/12/14 for a suicide attempt with first note dated 3/20/14.</p> <p>4 of 10 files evidenced information sharing, other than the initial referrals from/to behavioral health care management. 4 files were not applicable. In one file, MHNet documented that the member stated they were out of 2 medications for seizure disorder and member was advised that they would let the medical</p>	



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

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
	<p>call if the member does not keep the appointment, and follow-up for authorization of continued treatment where necessary.</p> <p>P/P Chapter 5 Managing Ongoing Care provides the procedure for initiating BH CM. This includes at least 2 phone attempts at different hours of the day, mailed letter, call attempt 10 days after the letter, and efforts to obtain alternate member contact information from providers, PH CM, and the MCO.</p> <p>The sample 30-day plan provided was an Intensive Care Management Plan for a member with an inpatient stay that included the assessment, care plan, follow-up plans/appointments, and follow-up contacts with member and providers.</p> <p>Note: A possible QOC issue was identified in the file review: The female member had been inpatient for suicidal ideation. The referral form had a notation of the member communicating that her PCP had refused to see her and she had been unable to fill her antidepressant prescription for 2 months prior to her admission. In response, the CM notes indicated that she needs a new PCP and has problems getting meds due to lock-in status. It was not clear if the member got a PCP reassignment or if she was able to obtain her</p>		<p>care manager know and she would probably call member. The next MHNet note is 2 months later indicating that the member had all medication.</p> <p>Although there appears to have been communication between CoventryCares and MHNet, it wasn't documented in the record. Additionally, in another file the referral to MHNet was documented on 6/20/14. On 9/4/14 the medical care manager discussed the need for a mental provider with the member and it was noted that referral had been made however member reported never receiving a call. CoventryCares care manager did a 3 way call to MHNet to get information about services. There was no MHNet documentation during this timeframe.</p> <p>Note: Documentation was available from the CoventryCare medical record, but very little documentation from MHNet. Many cases ended after one outreach attempt with UTC and a letter sent or care manager spoke with member with no further documented outreach conducted.</p> <p>During the onsite interview it was explained that MHNet employees were</p>	



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

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
	<p>medications, or if the difficulties getting her depression meds were resolved.</p> <p>Also, the claim that the PCP refused to see the member and she could not get her medications was not directly addressed despite that fact that the member complained she had subsequent suicidal ideation and was admitted to an inpatient facility.</p> <p>The member's reliability could not be determined from the case documentation, but in any case, this should have been investigated and confirmed or referred as a potential QOC issue. Note that the member may have had a 30 day plan that was not available for review onsite.</p> <p>In the interview, the case was discussed with the MCO and CCKY indicated that the issue would be investigated. To date, no additional information has been received.</p> <p><u>Recommendation for CCKY</u> CCKY/MHNet should address the following:</p> <ul style="list-style-type: none"> - Ensure that more than one outreach attempt is made for members referred for BH issues. - Ensure that when members are referred for outpatient treatment and/or appointments are scheduled, that follow-up is conducted to ensure that the member keeps the appointment. <p>Ensure there is documentation of information</p>		<p>not functioning as care managers, but mainly as prior authorizations employees. The employees are in a transition phase and being integrated. All employees are receiving education for behavioral health care management and medical care management.</p> <p><u>Recommendation for CoventryCares</u> CoventryCares/MHNet should address the following:</p> <ul style="list-style-type: none"> - Ensure that more than one outreach attempt is made for members referred for BH issues. - Ensure that the care manager participates in discharge planning if the member has been hospitalized. - Files should contain documentation of information sharing between physical health and behavioral health, monitoring of diagnosis, treatment, and follow-up and medication usage. 	<p><u>MCO Response</u> The MHNet utilization manual chapter 9 has been updated to state two outreach attempts are made for members referred for BH issues.</p> <p>The MHNet utilization manual chapter 6 has been updated to include that the care manager participates in discharge planning if the member has been hospitalized</p> <p>The Coordination of Care Screening form has been updated and is part of the members file to share information between physical health and behavioral health.</p>



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

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
	<p>sharing and monitoring of diagnosis, treatment, and follow-up and medication usage.</p> <p>MCO Response: Based upon CCKY's prior relationship as separate companies, MHNet has no access to the medical side of members' records, and Health Services staff has no access to Behavioral Health. During any audit or chart review, MHNet will ensure to pull records of members who have had coordinated care (through the standard Coordination of Care process) so that CCKY can evidence our coordinated services to those members with comorbid BH and medical conditions. CCKY is currently in the process of integrating BH and Health Services to provide a holistic care model for members. Until this is fully integrated, the corresponding medical health records will need to be requested from Health Services by the reviewer to accurately reflect coordination efforts.</p>			
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Full-2013			



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

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 require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.	Full-2013			
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-2013			
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full-2013			
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	<p>Substantial - Provider Quick Reference Guide (page 15) indicates a procedure must be in place to contact members who missed their appointments; however a timeframe is not indicated.</p> <p>Recommendation for CCKY CCKY/MHNet should add the 24 hour timeframe to the Provider Quick Reference Guide.</p> <p>MCO Response: CCKY has sent a request to marketing to update the Provider Quick Reference Guide to reflect the 24 hour timeframe. CCKY is currently awaiting a timeline for completion.</p>	Minimal	<p>The CoventryCares of Kentucky Provider Manual on page 28 does not include the following elements: Behavioral health Service Providers or attempts should occur within twenty-four (24) hours to reschedule appointments.</p> <p>The MHNet Utilization Management Program Description on page 8 discusses Care Management re-contacting the member and assisting in re-scheduling additional follow-up appointments when discharged from an acute setting. Additionally, a timeframe is not indicated.</p>	<p>DMS Response Since IPRO recommended that the policy be updated in the previous three compliance reviews, an LOC /CAP maybe issued.</p> <p>MCO Response Continuity and Coordination of Care (CM – 035) which includes the language that Behavioral Health Service providers will contact members who have missed appointments within (24) hours to reschedule appointments has been updated and approved by the plan.</p>



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

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
			<p>The MHNet Behavioral Health Provider Quick Reference Guide states that there is a protocol/process for documenting communication or attempted communication with the member following a missed appointment, but no timeframe noted.</p> <p>The MHNet Utilization Improvement Manual on page 129 discusses, but does not include a timeframe.</p> <p>Following the onsite review, the MCO provided a recently revised copy of Continuity and Coordination of Care (CM – 035) which includes the language that Behavioral Health Service providers will contact members who have missed appointments within (24) hours to reschedule appointments.</p> <p><u>Recommendation for CoventryCares</u> The policy revisions should be approved and implemented.</p>	
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				



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

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
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-2013			
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-2013			
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law.	Full-2013			



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

Final Findings

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



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

Final Findings

Behavioral Health Services (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.	Full-2013			
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 behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);	Full-2013			
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-2013			
D. Protect the confidentiality of Member information and records; and	Full-2013			



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

Final Findings

Behavioral Health Services <i>(See Final Page for Suggested Evidence)</i>				
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
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full-2013			
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.				



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

Final Findings

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	2	1	1	0
Total Points	6	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		2.25		

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



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

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



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

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: CoventryCares of Kentucky

Final Findings

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
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				
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-2013			
B. Retrospective utilization review services;	Full-2013			
C. Formulary and non-formulary services, including prior authorization services;	Full-2013		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-2013			
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors; and	Full-2013			
F. Coverage for all drugs for which a federal rebate is available and has been provided by DMS.	New Requirement	Non-Compliance	The Technology Assessment (7000.20) policy did not include language pertaining to the coverage for all drugs for which a federal rebate is available. During the onsite review, the MCO provided a revised copy of Pharmaceutical Management Procedures (RX-1003) revised on	



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

Final Findings

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
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
			2/2015 which meets the contract language.	
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-2013			
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-2013			
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-2013			
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	Full-2013			



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

Final Findings

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
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
responsible for processing components required for paper Claims.				
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-2013			
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-2013			
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.	Full-2013			
37.12 Prospective Drug Utilization Review Report				



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

Final Findings

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
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 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.	Full-2013		Includes review of 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 (see Quarterly Desk Audit Reports)	



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

Final Findings
Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	0	0	0	1
Total Points	0	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				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
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KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: CoventryCares of Kentucky

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