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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - This requirement is addressed in PHP's 2013 Quality Improvement (QI) Program Description, which describes the Plan's comprehensive infrastructure for the continuous monitoring, evaluation and improvement in care, safety, and service. Evidence for ongoing assessment, monitoring and evaluation is reflected in the QI Work Plan and Program Evaluation.	Full	Includes review of MCO Report #84 QAPI Program Description. Passport's 2014 Quality Improvement (QI) Program Description describes the MCO's comprehensive infrastructure for the continuous monitoring, evaluation and improvement in care, safety, and service. Evidence of ongoing assessment, monitoring and evaluation is reflected in the QI Work Plan and Program Evaluation.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Full - This is addressed in PHP's 2013 QI Program Description, which includes activities such as: conducting medical record reviews against documentation standards and Continuity and Coordination of Care standards; assessing provider/practitioner access and availability and reviewing member complaints regarding access; conducting Performance Improvement Projects (PIPs), calculation of HEDIS and Healthy Kentuckian performance measures, monitoring over and under-utilization, and monitoring and evaluating for improvements to physical health outcomes resulting from	Full	Passport's 2014 QI Program Description includes activities such as: conducting medical record reviews against documentation standards and Continuity and Coordination of Care standards; assessing provider/practitioner access and availability and reviewing member complaints regarding access; conducting Performance Improvement Projects (PIPs), calculation of HEDIS and Healthy Kentuckian performance measures, monitoring over and under-utilization, and monitoring and evaluating for improvements to physical health outcomes resulting from behavioral health integration into the member's overall	

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	behavioral health integration into the member's overall care.		care.	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - This requirement is addressed in the 2013 QI Program Description, which outlines a structured and organized set of activities and processes related to quality of care and includes: objectives, goals, scope, identified barriers, and planned activities that address the quality and safety of clinical care and quality of services. Also included are provisions for developing and implementing systematic data collection methodologies and developing planned and ongoing quality initiatives. These structures and processes are reflected in the QI Work Plan.	Full	Passport's 2014 QI Program Description, outlines a structured and organized set of activities and processes related to quality of care and includes: objectives, goals, scope, identified barriers, and planned activities that address the quality and safety of clinical care and quality of services. Also included are provisions for developing and implementing systematic data collection methodologies and developing planned and ongoing quality initiatives. These structures and processes are reflected in the QI Work Plan.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.	Full - The 2013 QI evaluation has been updated to include a section on the External Quality Review Organization's (EQRO) Annual Evaluation. In conjunction with the EQRO, PHP Quality Program evaluation and activities include linkage of activities and processes across departments, with objectives that include continuously monitoring and analyzing clinical, safety and service indicators. Opportunities	Full	Passport's 2013 QI Evaluation includes a section on the External Quality Review Organization's (EQRO) Annual Evaluation. In conjunction with the EQRO, Passport Quality Program evaluation and activities include linkage of activities and processes across departments, with objectives that include continuously monitoring and analyzing clinical, safety and service indicators.	

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	for improvement identified in QI activities and reported in the Program Evaluation are reflected in the QI Work Plan. System changes implemented as a result of PIPs are described in the QI Evaluation and PIP reports.		Opportunities for improvement identified in QI activities and reported in the Program Evaluation are reflected in the QI Work Plan. System changes implemented as a result of PIPs are described in the QI Evaluation and PIP reports.	
The QAPI program shall be developed in collaboration with input from Members.	Full - The Quality Member Access Committee (QMAC) meets every two months and must meet at least four times per year. Ongoing oversight of program deliverables has been delegated to the Partnership Council, which includes member advocates. Member advocates are also represented on the Quality Medical Management Committee (QMMC). QMAC minutes demonstrate active participation of members in discussion of QI activities, including review of the Program Description.	Full	The Quality Member Access Committee (QMAC) met four times in 2014 in accordance with its Charter. Ongoing oversight of program deliverables has been delegated to the Partnership Council, which includes member advocates. Member advocates are also represented on the QMMC. QMAC minutes demonstrate active participation of members in discussion of QI activities, including review of the QI Program Description.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - The QMAC is charged with accountability for the review of member complaints for quality of care and sentinel events having the potential for an adverse effect on members and as referred to the QMMC by MCO staff. The QMMC reviews aggregate data of	Full	The QMAC is charged with accountability for the review of member complaints for quality of care and sentinel events having the potential for an adverse effect on members and as referred to the QMMC by MCO staff.	

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	member complaints, transfers, surveys, as well as the results of provider audits, and makes determinations regarding corrective action to be taken. QMMC and QMAC minutes were provided and include discussion of member-related issues and performance improvement activities.		The QMMC reviews aggregate data of member complaints, transfers, surveys, as well as the results of provider audits, and makes determinations regarding corrective action to be taken. QMMC and QMAC minutes were provided and include discussion of member-related issues and performance improvement activities.	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	Full- The Plan has held NCQA accreditation with "Excellent" status for its Medicaid product line from September 16, 2008-September 16, 2012. Reaccreditation will extend to September 30, 2014, with Excellent status.	Full	Passport received "Commendable" accreditation status effective 9/4/2014 through 9/30/2017.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	Full- Addressed -Copy of 2011 certification status provided, which extends to September 30, 2014.	Full	A copy of the 2014 accreditation certificate was provided, which extends to September 30, 2017. For the accreditation report of findings, the MCO provided the scoring summary and HEDIS/CAHPS and Standards scores as well as findings at the category, standard, and element levels; Must Pass Results; and NCQA recommendations. The overall scores were as follows:	

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			HEDIS/CAHPS score: 38.8/50 Standards score: 48.7/50 Total score: 87.5/100 Star ratings: Access and Service: 4 Qualified Providers: 4 Staying Healthy: 3 Getting Better: 1 Living with Illness: 3 Standards Scores: Quality Measurement/Improvement: 93.3% UM: 99.4% Credentialing: 99.2% Member Rights/Responsibilities: 100% Recommendations: QI – Evaluate member appeals by collecting valid data using each of the 5 (accreditation) categories. UM – Demonstrate that pre-delegation assessment was conducted for delegates contracted < 12 months.	
Annually, the Contractor shall submit the QAPI program description document to the Department for review.	Full- The Plan provided attestation of timely submission of the QAPI Program Description.	Full	The QI Program Description, Report #84, was submitted with the Q3 2014 reports, 7/31/14.	
The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of	Full - The 2013 QI Program Description outlines the goal to provide support to monitor and evaluate the quality of health care on an ongoing basis, such as	Full	The 2014 QI Program Description outlines the goals to assess and improve the quality of care, safety, and service throughout the MCO.	

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Behavioral Health Services provided to Members.	acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care and behavioral health are studied and prioritized for performance measurement, monitoring and evaluating for improvements to physical health outcomes resulting from behavioral health integration into the member's overall care, performance improvement and/or development of practice guidelines. Onsite staff indicated that behavioral health indicator monitoring was just beginning (HEDIS Antidepressant Medication Management, ADHD, schizophrenia measures). The Plan noted that Beacon, the behavioral health vendor, reports behavioral health measures. The Plan provided evidence of PIPs focused on behavioral health and innovative programs that include a psychotropic drug program. As per the QI Program Evaluation, the Plan is collaborating with Beacon on a project focused on members with diabetes and depression, which includes screening members with diabetes for depression and counseling		Behavioral Health services are delegated to Beacon Health Strategies (BHS). The Passport QI Program Description includes among its objectives to perform appropriate oversight of delegated activities; that Passport believes in a "Partnership" relationship with its delegates; provides oversight to assure compliance with CMS and State regulatory standards; and collaborates with vendors to continuously improve health service quality and safety. The BHS 2014 QI Program Description, on page 5, states that a core function is to perform continuous evaluation, measurement and improvement of the services delivered by BHS to all members, provider networks and health care organizations. As described in the 2014 QI Program Description, 2013 QI Program Evaluation and 2014 QI Work Plan, behavioral health quality is addressed by the QI program as follows: HEDIS 2014 reporting – Follow-Up After Hospitalization for Mental Illness, Antidepressant Medication Management,	

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	for those at risk. The Plan is also collaborating with Beacon to address pregnant women with behavioral health issues.		Follow-Up Care for Children Prescribed ADHD Medication, several HEDIS measures for members with schizophrenia and/or bipolar depression and medical co-morbid conditions (diabetes, cardiovascular disease) and medication adherence for members with schizophrenia. Kentucky Performance Measures: Adolescent Screening and Counseling for Tobacco use, Alcohol/Substance Use and Screening for Depression, Prenatal and Postpartum Screening for Depression. Monitoring GeoAccess and availability of BH providers. PIPs – Psychotropic Drug Intervention Program, Statewide Collaborative: Use of Psychotropic Medications in Children and Adolescents. QI Initiative: Screening for Depression and Adherence to Antidepressant Medication (per QI Work Plan, pages 134-135.) Beacon's 2014 QI Program Description includes the following initiatives: HEDIS behavioral health measures, alcohol and drug use, continuity and coordination of care for physical and behavioral health, provider accessibility and availability, and patient safety.	

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The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the member's overall care.	Full - PHP collects and reports several HEDIS behavioral health measures, including Antidepressant Medication Management, ADHD and the Schizophrenia measures as well as CAHPs questions on behavioral health care. Interventions based on the findings of these measures included efforts to improve the integration of behavioral and physical health. As noted above, the Plan is collaborating with Beacon to address pregnant women with behavioral health issues and depression screening for members with diabetes.	Full	As noted in the QI Program Description and QI Work Plan, Passport reports several HEDIS behavioral health measures, Kentucky Performance Measures related to behavioral health and is conducting QI initiatives on access to and options for substance abuse treatment and depression screening and medication, and two PIPs focusing on behavioral health topics. The BH subcontractor, Beacon also reports several QI initiatives in progress as noted above. The MCO is collaborating with Beacon to address pregnant women with behavioral health issues and depression screening for members with diabetes. Based upon screening results, members are referred to Beacon and are discussed during weekly case conferences.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and	Full- This requirement is addressed in the 2013 Program Evaluation, which includes a comprehensive evaluation program and includes step taken to address issues raised by the EQRO. The Plan provided attestation that the	Full	Includes review of MCO Report #85 QI Plan & Evaluation. The 2013 QI Program Evaluation includes a comprehensive evaluation of the program and steps taken to address any	

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procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Members. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which 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.	evaluation was submitted by July 31.		issues raised by the EQRO and was approved by the QMMC at its June 2014 meeting. Passport submitted Report #85 2013 QI Evaluation to DMS with the Q3 2014 reports.	
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Full- Providing information to the EQRO is included in the QI Program Evaluation. The EQRO is provided with information needed to fulfill the mandatory and optional activities, including documentation related to performance improvement projects, performance measures and information needed for the focused studies. Documentation for the compliance review was provided to the EQRO by	Full	The 2014 QI Program Description and Work Plan and the 2013 QI Evaluation include references to collaboration and cooperation with EQRO activities throughout the documents. Passport has been responsive to all requests for data, medical records, and information related to EQRO activities. Documentation for the compliance review was provided timely to the EQRO, IPRO.	

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	2/28/14.			
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.	Full - This requirement is addressed as reflected in the Plan's submitted documents. The EQRO's recommendations have been incorporated into PHP's Program Description and Program Evaluation and the various committees are provided with the results of the EQRO's recommendations. Interventions to improve quality of care have been designed centering on the EQRO's recommendations.	Full	The 2014 QI Program Description and Work Plan and the 2013 QI Evaluation include references to collaboration and cooperation with EQRO activities throughout the documents. Passport has been responsive to all requests for data, medical records, and information related to EQRO activities. Documentation for the compliance review was provided timely to the EQRO, IPRO.	
21.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Full - PHP has cooperated with the EQRO in providing the EQRO with files/samples to conduct focused studies, in responding to issues addressed in connection with performance improvement projects and in providing necessary documentation to conduct the compliance reviews. The Plan has also submitted performance measure documentation for validation as requested.	Full	Addressed in the 2014 QI Program Description and Work Plan and the 2013 QI Evaluation. Passport has complied readily with all EQRO requests for data, information, documentation and medical records and has accepted EQRO recommendations and suggestions.	
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external	Full- The Plan has provided provider and member information for EQR activities, including focused studies,	Full	Addressed in the 2014 QI Program Description and Work Plan and 2013 QI Evaluation.	

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independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.	validation studies, and annual compliance review. The Provider Manual explains the role of the EQRO.		Passport has provided medical records for focus studies and validation studies, performance measure validation, and the compliance review in 2014.	
21.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - In conjunction with the EQRO, PHP Quality Program evaluation and activities include linkage of activities and processes across departments, with objectives that include continuously monitoring and analyzing clinical, safety and service indicators. In addition, PHP participated in calls with DMS and EQRO during the review period to discuss selected health outcome measures as appropriate. Also, select health outcomes measures are chosen for monitoring care in collaboration with DMS and the EQRO. New or revised measures that are clinically sound and consistent with Healthy Kentuckians goals, and that complement the Plans' quality improvement goals, are discussed collaboratively with DMS, EQRO, and	Full	No potential quality issues have been identified through the EQRO activities. As described in the 2013 QI Evaluation, Passport submits corrective action plans for all compliance findings of minimal or non-compliance, as required.	

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	the Plans. PHP responded to compliance review findings and there is evidence of incorporation of recommendations from 2013 review into documentation and processes in the submission of responses to findings and Corrective Action Plans.			
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - The documentation of follow-up activities for review findings from prior review was submitted by the Compliance Director. The Director of Quality Improvement is the person responsible for implementing the QI Program. The Manager of Quality Improvement oversees the day-to-day operations of the Quality Improvement Department. Additionally, there are seven QI staff members who perform the QI Department responsibilities.	Full	As described in the 2014 QI Work Plan, EQRO Assessment, the Compliance Director is responsible for submitting responses/CAPs for EQRO findings. Passport submitted CAPs for all deficiencies identified in the 2014 Compliance Review, as required.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and	Full - The 2012 QI Program Evaluation, which was completed in 2013 when data were available, and the 2013 Work Plan were updated with the EQRO's recommendations and were submitted to the appropriate committees for approval as evidenced in committee minutes.	Full	The 2013 QI Program Evaluation and the 2014 QI Program Description were updated with the EQRO's recommendations and were submitted to and approved by the QMMC at the June 2014 meeting.	

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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 Plan submitted a corrective action plan for EQR findings within 60 days and resolved issues within six months as documented in EQR response and CAP submission letters. An action plan based on EQRO findings is noted in the Program Evaluation.	Full	For the 2014 Compliance Review, Passport submitted all required CAPs within the timeframes designated by DMS and the action plans and timeframes have been approved by DMS. There have not been any other EQRO findings that required corrective action.	
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full - The EQRO findings are included in the QI Program Description and in the Program Evaluation, and initiatives incorporating the findings are described in the 2013 QI Work Plan. The Work Plan was updated based on EQRO recommendations.	Full	The 2014 QI Program Description and Work Plan and the 2013 QI Evaluation describe integration of EQRO tasks into the QI Program, including PIPs, Compliance Findings, Performance Measures, and the Annual EQR Technical Report. Passport has implemented the necessary actions and activities as seen in the 2014 QI Work Plan.	
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-No evidence of disagreement.	Not Applicable	Passport did not submit any position of disagreement with EQRO findings. The MCO was given an opportunity to provide responses to the preliminary Compliance Review findings and the responses were considered by DMS and IPRO, the EQRO.	
19.3 QAPI PLAN				

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The Contractor shall have a written QAPI work plan that	Full - The 2013 Work Plan was provided. The QI Work Plan includes objectives, goals, scope, identified barriers, and planned activities that address the quality and safety of clinical care and quality of services.	Full	Includes review of MCO Report #17 QAPI Work Plan. Passport submitted Report #17, the 2014 QI Work Plan and updates, with each quarterly report in 2014, as required. Updates are entered quarterly including measurements and interventions.	
outlines the scope of activities and	Full - The QI Program description describes the Work Plan and states that it includes the scope of activities. A review of the 2013 Work Plan indicates that the scope of each activity is included.	Full	The 2014 QI Program Description, QI Activities to Fulfill the Scope, includes a high-level description of the scope of the QI Program and references the QI Work Plan for more detailed information. A review of the 2014 Work Plan revealed that the scope of each activity is described in detail.	
the goals,	Full - Addressed -- The Work Plan includes program goals for the activities, which are quantifiable.	Full	Addressed in the 2014 QI Work Plan, which includes quantifiable goals for each of the activities and results are updated in each quarterly Report #17.	
objectives, and	Full - Objectives are included in each of the focus areas of the Work Plan. **Recommendation for PHP** The objective for each activity is stated but, it would be helpful if it were	Full	Passport's 2014 QI Work Plan includes Goals and Objectives that are now clearly identified, in accordance with recommendation from last EQRO review.	

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	labeled as such to make it easier to identify. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by updating the 2nd Qtr 2014 Work Plan document, and going forward, Goals and Objectives are clearly marked. Passport has submitted a one page screen shot noting the change. 2014 QI Workplan-IPRO ...			
timelines for the QAPI program.	Full - Quality improvement activities are reported quarterly, and time frames of completion of activities are included in the Work Plan. Although the Plan did not submit an annual Executive Summary for review for this period, 2013 Work Plan goals include target dates and the status of activities are updated quarterly as noted above.	Full	The 2014 QI Work Plan includes the frequency and method of monitoring for each activity. At a minimum, the Work Plan is updated quarterly (see QMMC minutes) and Report #17 is submitted. The 2014 QI Work Plan contains timeframes and target dates for each of the goals and objectives.	

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New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	Full - Work Plan activities, goals, barriers, interventions and measurement, are updated quarterly based on performance and barriers noted as evidenced by the submitted 2013 QI Work Plan. A section regarding EQRO recommendations and activities is included in the Work Plan.	Full	The 2013 QI Evaluation provides an overall assessment of effectiveness of the QI Program activities and describes opportunities for 2014 which are incorporated into the 2014 QI Work Plan. The 2014 QI Work Plan activities, goals, barriers, interventions and measurements are updated quarterly based on performance and the barriers to improvement are described. A section regarding the EQRO recommendations and activities is included in the Work Plan on page 130.	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full - The QI Program is submitted to the Quality Medical Management Committee, the Partnership Council, and the UHC Board for review and approval. The UHC Board has authority and responsibility for the quality of care delivered under the product Passport Health Plan. The Quality Medical Management Committee (QMMC) and Director of Quality have the responsibility for planning, designing, implementing and coordinating the patient care and clinical quality	Full	The QI Program and Work Plan are submitted to the QMMC, the Partnership Council, and the University Health Care (UHC) Board for review and approval. Review and approval is evidenced : QMMC – in the 2014 QI Work Plan on page 124, Partnership Council – 7/15/2014 meeting minutes. Approval signature pages were provided for the 2013 QI Evaluation and 2014 QI Program Description/Work Plan. Signatures included the QI Director, Medical Director, Chairman, and CEO.	

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	improvement activities as delegated by the Partnership Council.			
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - Ongoing oversight of program deliverables has been delegated to the Partnership Council. The Quality Medical Management Committee (QMMC) and Director of Quality have the responsibility for planning, designing, implementing and coordinating the patient care and clinical quality improvement activities as delegated by the Partnership Council. QMMC and Partnership Council minutes reflect approval of the QAPI Program Description, Evaluation, and QI Work Plan.	Full	Addressed in the 2014 QI Program Description, Authority. The UHC Board has authority and responsibility for QI Program and delegates ongoing oversight of program deliverables to the Partnership Council. The Quality Medical Management Committee (QMMC) and Director of Quality have the responsibility for implementation of the program (QI Program Description page 3). QMMC and Partnership Council minutes reflect approval of the QAPI Program Description, Evaluation, and QI Work Plan and conduct of responsibilities.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full- The QMMC provides recommendations regarding provider education and interventions, health education programs, and other Plan initiatives. QMMC committee meeting minutes indicate recommendations to accept the Program Description and quarterly Work Plans and include a review of survey results. Both QMMC	Full	Addressed in the QI Program Description, Appendix 1 - Committee Descriptions, where the responsibilities of the UHC Board, Partnership Council, and QMMC are described. The Partnership Council meeting minutes, QMMC committee meeting minutes and approval signatures demonstrate that	

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	and Partnership Council minutes reflect review of QI and UM Program Evaluations, medical record audits, guideline compliance and other reports.		responsibilities are fulfilled.	
review on an annual basis of the QAPI program; and	Full- The QI Program Evaluation discusses the structure of the organization throughout 2012. The Evaluation considers the network management activities and the Plan's credentialing and recredentialing activities, and the clinical and service activities. It concludes with an overall assessment of effectiveness and opportunities for 2013. The QI Program Evaluation was reviewed by the QMMC and Partnership Council as per meeting minutes.	Full	Addressed in the QI Program Description, Authority and in Appendix 1 – Committee Descriptions. Review and approval of the QI Program Description, QI Work Plan and QI Evaluation by responsible committees is evidenced in meeting minutes and approval signatures.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full- The Program Evaluation states that an objective of the QI Program is to continuously monitor and analyze key clinical and service indicators. QMMC and Partnership Council meeting minutes reveal discussion of findings of quality improvement initiatives. The 2013 QI Work Plan includes updates to interventions based on barriers and concerns noted, as well as interventions to address review findings.	Full	Addressed in the 2014 QI Program Description, Objectives, page 7, and the 2013 Program Evaluation, page 1, Introduction. Reflected in the 2013 QI Evaluation, page 75, Program Impact and Recommendations for 2014, in the 2014 QI Work Plan quarterly updates as well as in committee meeting minutes.	
The Contractor shall have in place an organizational	Full - The QMMC provides direction to,	Full	Addressed in the 2014 QI Program	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	and oversight of, management and subcommittee functions responsible for the provision of clinical care and services. The QMMC is responsible for approval of the annual QI and UM Program descriptions, twice annual review of the QI Work Plan and Annual QI and UM Evaluations.		Description, Authority, and Appendix 1 – Committee Descriptions. The QMMC meeting minutes provide evidence of fulfillment of responsibilities.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Full- The QMMC is composed of a Clinical Pharmacist, PHP's Chief Medical Officer, the Medical Director, a Health Department representative, and practitioner representatives from the following disciplines: Internal Medicine, Pediatrics, OBGYN and Chiropractic's, other quality, provider relations and UM PHP staff, a Medical Ethicist and a Consumer Advocate. The Plan has had difficulty recruiting members for the Women's Health Committee, which met only once in the review period. The Plan has OB representation on the QMMC. **<u>Recommendation for PHP</u>** The Plan should continue efforts to recruit members for the Women's health Committee. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation	Substantial	Addressed in the 2014 QI Program Description, Appendix 1, Committee Descriptions which states that the QMMC is composed of a Clinical Pharmacist, Passport's Chief Medical Officer, the Medical Director, a Health Department representative, and practitioner representatives from the following disciplines: Internal Medicine, Pediatrics, OB/GYN, Neonatology and Chiropractic's, other quality, provider relations and UM Passport staff, a Medical Ethicist and a Consumer Advocate. Review of QMMC minutes showed that there is no evidence of a Medical Ethicist or Consumer Representative member, the OB/GYN representative did not attend meetings, and often there was sparse attendance from other medical disciplines. The MCO has OB representation on the QMMC.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by continuing to review all committee representatives, scope, and responsibilities in order to ensure that we have appropriate feedback and recommendations from members, providers, community resources, and advocates so that we can provide quality healthcare. Specifically for QMMC, Dr. Houghland, Vice President and Chief Medical Officer, is actively working to recruit additional members to the committee. There is a consistent core group of providers that attend, however Dr. Houghland's goal is to grow this group in order to have more provider and member representation. Specifically for the Women's Health Committee, Dr. Griffin, OB Medical Director,

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	by currently investigating the potential of adding a Medical Director to the staff specifically trained as an OB/GYN. One of the objectives for the Medical Director will be to engage his/her peers in active participation in Passport's Women Health Initiatives in order to improve the health and quality of life of female Kentuckians.		During the onsite review, Passport reported efforts to revamp the committee structure. Passport added a staff Medical Director who is an OB/GYN and plans to re-establish the Women's Health Committee. The MCO has not been able to identify a Medical Ethicist or consumer representative for the QMMC; however, the QMAC includes consumer representation. **Recommendation for Passport** Passport should continue to assess the QMMC committee structure. The MCO may want to consider offering membership to a consumer advocacy group representative in lieu of a consumer representative. The MCO should continue efforts to recruit members for the Women's health Committee.	is actively working to re-engage our OB providers to assist with quality improvement of women's health as a whole. He is pursuing hosting at least one meeting in 2015 and establishing a regular meeting schedule going forward.
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.	Substantial - The QMMC meets monthly and must meet at least eight times during the year to meet QI Program objectives. Committee minutes were available for each meeting, and QMMC	Full	Addressed in the 2014 QI Program Description, Appendix 1 – Committee Descriptions. The QMMC must meet 8 times during year in order to meet QI Program objectives. The MCO defines a	

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	minutes indicate that discussion is active and member concerns are addressed. The QMMC met monthly during the review period; however, there was no quorum for 5 of the meetings, including those taking place from July through October of the review period (1/8/13, 7/2/13, 8/6/13, 9/10/13, and 10/1/13). FAX votes were obtained when there was no established quorum. **Recommendation for PHP** The Plan should ensure that QMMC meets regularly with the intended interdisciplinary structure. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by currently reviewing all of its Quality Committees to be sure we include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs, as well as to cover all geographical areas of our Commonwealth.		quorum as attendance by 50% of the membership. Committee meeting minutes demonstrate that there were 8 meetings in 2014. The minutes indicate that discussion is active and member concerns are addressed. At 4 of the meetings at least 50% of voting members were present. Votes are taken by fax when there is no established quorum.	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be	Full - PHP's Delegation Oversight Manual stipulates that the delegate	Full	QAPI activities and responsibilities are addressed in the Delegation Oversight	

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integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	clearly define its quality improvement (QI) goals, structures and objectives and its quality improvement program. Delegation oversight reports, which include quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the Delegation Oversight and QMMC committees. Encounter files must be reported weekly by the delegates. The Provider Manual provides for internal monitoring and auditing of provider and subcontractors and if issues are found, contractors must provide corrective action taken. Contractors must correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.		Manual which stipulates that the delegate clearly define its quality improvement (QI) goals, structures and objectives and its quality improvement program and in the Provider Manual, Section 9, and Quality Improvement. Evidenced in delegation oversight reports, which include quality improvement activities. Encounter data submission is addressed in the Provider Manual, Section 15 Provider Billing Manual, 15.1.9 Submitting Member Encounters. Evidenced in the 2014 QI Work Plan and updates under Delegate Oversight. The Provider Manual addresses internal monitoring and auditing of provider and subcontractors and when issues are found, the contractors must provide a corrective action plan.	
The Contractor shall integrate other management	Full - The Program Description states	Full	Addressed in the QI Program Description,	

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activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.	that quality improvement activities are coordinated with other performance monitoring activities and management functions including, but not limited to utilization management, case and disease management, health management, risk management, patient safety, cultural and linguistic competency, credentialing, claims, member and provider services, and network development. Member Services, UM and Grievances and Appeals and other reports are reflected in QMMC meeting minutes. Delegation oversight findings, which include audit scores, interventions and quality improvement activities, are incorporated into the QI Program Evaluation and Work Plan, and are discussed in the Delegation Oversight and QMMC committees.		pages 4-5, QI Activities to Fulfill the Scope and pages 6-7, Purpose. Evidenced in the QMMC meeting minutes, QI Work Plan and updates and the 2013 QI Program Evaluation.	
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 special health care needs, use of preventive services, coordination of behavioral and	Full - The Chief Medical Officer (CMO) has been appointed by University Health Care to support the quality improvement committees outlined in this program by providing day-to-day oversight of quality improvement and credentialing activities. The CMO staff	Full	Addressed in the 2014 QI Program Description, pages 8-10, which describe the roles of the CMO and QI Department. Evidenced in the 2014 QI Work Plan which delineates the staff responsible for each activity, including lead and support roles	

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physical health care needs, monitoring and providing feedback on provider performance, involving Members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.	also includes two medical directors and one pharmacy director who each participate in and advise regarding implementation of the QI Program. The Director of Quality Improvement has been granted approval by the CEO of University Health Care to implement the QI Program. The Manager of Quality Improvement oversees the day-to-day operations of the Quality Improvement Department. Additionally, there are seven QI staff members who perform the QI Department responsibilities. The 2013 Work Plan includes staff responsible for each activity.		and also in the Partnership and QMMC meeting minutes.	
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	New Requirement	Full	Addressed in the QI Work Plan and evidenced in the quarterly reports provided. The 2014 QI Work Plan and updates were submitted for each quarter in 2014.	
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	Full - The 2013 QI Program Evaluation and the 2013 QI Work Plan contain evidence of ongoing monitoring and evaluation of clinical care quality, including trending of standardized	Full	Addressed in the 2014 QI Program Description, pages 3-7, Scope, QI Activities to Fulfill the Scope, Purpose, Goals, and Objectives.	

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care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.	quality indicators (HEDIS measures, Healthy Kentuckian measures), case management/disease management metrics, utilization metrics and trending of sentinel events and member concerns. HEDIS measures are used to identify adherence to guidelines as well as over- and under-utilization and access. PHP's HEDIS auditor indicated that PHP was fully compliant with all NCQA-defined IS Standards for HEDIS-applied data and processes. The Plan has begun reporting HEDIS behavioral health measures, including ADHD, follow-up of mental health hospitalization, Antidepressant Medication Management, and the schizophrenia and bipolar screening measures.		Evidenced in the 2013 QI Evaluation and the 2014 QI Work Plan and updates.	
B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full- One of the Plan's QI Program objectives is to perform a quality review of key clinical and service indicators to assess and improve member and practitioner satisfaction. These clinical and service indicators include reviews of: • Member and provider complaints for	Full	Includes review of MCO Report #23 Evidence Based Guidelines for Practitioners. Addressed in the 2014 QI Program Description, pages 3-7, Scope, QI Activities to Fulfill the Scope, Purpose, Goals, and Objectives as well as in the Provider	

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	care or service. • Sentinel events defined as any event involving member care that warrants further investigation for quality of care concerns. • National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®). • Application of current clinical guidelines. Clinical guidelines (Section 15 of the Provider Manual) • Application of medical record documentation and continuity and coordination of care standards. According to the 2012 Program Evaluation, at the time of medical record review in support of HEDIS®, medical records are reviewed annually to assess practitioner compliance with adopted clinical practice guideline standards. For measurement year 2011, medical records were assessed for the following: Coronary/Vascular Clinical Practical Guidelines (CPG), Diabetes CPG, Hypertension CPG and Perinatal Care CPG. CPG compliance audits for measurement year 2012 for these guidelines are documented in the 2013		Manual under Roles of the PCP, Responsibilities of All Providers, Medical Record Standards, EPSDT, and in the sections on Dental Network. Evidenced in the 2013 QI Evaluation, 2014 QI Work Plan and updates, Report #23 Evidence Based Guidelines for Practitioners which contains a list of the guidelines adopted/revised each quarter. Review of guidelines is also reflected in Medical Management Committee (MMC) and Partnership meeting minutes.	

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	CPG Compliance Results document that was submitted by the Plan. Partnership Council and QMMC meeting minutes reveal discussion of CPG. CPG audit reports are also reported and reviewed in the QMMC, including how to improve performance.			
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full- The 2013 Program Evaluation presents results of practitioner compliance with the Clinical Practice Guidelines and barriers. Interventions to address them are identified.	Full	Addressed in the QI Program Description, Authority, Scope, Goals, and Objectives. Evidenced in the 2013 Program Evaluation that presents results of practitioner compliance with the Clinical Practice Guidelines (CPGs) and barriers. Interventions to address the barriers are identified.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full- The Provider Manual describes PHP's Program Integrity Plan that requires monitoring and auditing of its contractors and its subcontractors. If issues are found contractors must provide corrective action taken. According to the Provider Manual, practitioners must achieve an average score of 80% or higher on medical record review. PHP will monitor practitioners' scoring less than 80% through corrective action plans and re-	Full	Addressed in the QI Program Description, Authority, Scope, Goals, and Objectives. According to the Provider Manual, page 55, practitioners must achieve an average score of 80% or higher on medical record review. Passport indicates that it will monitor practitioners' scoring less than 80% through corrective action plans and re-evaluation. Evidenced in the 2013 Program Evaluation that presents results of practitioner compliance with the CPGs and barriers.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	evaluation. Provider audit findings and actions are reported in the QI Work Plan.		Interventions to address the barriers are identified and actions are reported in the QI Work Plan.	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full- Several committees composed of members from multiple disciplines meet regularly -- QMMC, QMAC, the Partnership Council -- to discuss issues related to patient care and satisfaction, provider-related issues and internal systems. Multiple departments participate in Plan QI activities.	Full	Addressed in the 2014 QI Program Description as well as in Appendix 1 – Committee Descriptions. Evidenced in the meeting minutes for the QMMC and the Partnership Council. In addition, multidisciplinary staff from a variety of departments participates in QI activities, as evidenced in the 2014 QI Work Plan.	
D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.	Full- PHP submitted two PIP proposals: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP). The proposals were submitted in August, 2013, and updated and re-submitted on December 2013. The Plan also submitted reports of ongoing PIPs, including Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections (Antibiotics PIP), Dental Care in Children with Special Health Care	Full	Quarterly and annual submission of Reports #90 and #92 include annual PIP proposal and reports of baseline, interim, and final measurements for PIPs in progress. Passport submitted the following PIPs in 2014: Proposals: Reducing Postpartum Readmissions and Statewide Collaborative - Use of Antipsychotic Medications for Children and Adolescents. Baseline Reports: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan	

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	Needs (Dental PIP), Reduction of Emergency Room Care Rates (Emergency Room PIP), and Smoking Cessation: Yes You Can! (Smoking Cessation PIP).		and Psychotropic Drug Intervention Program. Final Reports: Reduction of Emergency Room Care Rates and Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections.	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Full- The Program Evaluation describes PHP's efforts to develop and maintain Clinical Practice Guidelines (CPGs), which are reviewed and approved by the QMMC. The Plan's goal is to adopt, maintain, and implement clinical practice guidelines that support clinical management of acute and chronic conditions relevant to PHP's membership. Eleven Clinical Practice Guidelines were approved by QMMC during 2012. Clinical Practice Guidelines updates were made on the PHP website and in the Provider Manual. The Plan submitted a document entitled "CPGs Approved in 2013" as well; these CPGs are on the provider website. There were fourteen Clinical Practice Guidelines reviewed and approved or recommended for approval in 2013.	Full	Addressed in the 2014 QI Program Description, pages 3-7, Scope, QI Activities to Fulfill the Scope, Purpose, Goals, and Objectives as well as in the Provider Manual under Roles of the PCP, Responsibilities of All Providers, Medical Record Standards, EPSDT, and in the sections on Dental Network. Evidenced in the 2013 QI Program Evaluation, results of monitoring provider compliance with guidelines, 2014 QI Work Plan activities to adopt and distribute CPGs, in QMMC meeting minutes, Report #23 Evidence Based Guidelines and Passport provided copies of the guidelines that have been adopted.	

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	QMMC minutes include discussion of CPGs including Preventive Services, Anxiety and Major Depressive Disorder.			
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	Full- According to PHP's Provider Manual, PHP makes every effort to ensure that current scientific data and expert opinion are the basis for each guideline. Each guideline is evaluated as new data becomes available or at a minimum of every two years. PHP monitors provider compliance and member outcomes related to these clinical guidelines for quality improvement initiatives and re-credentialing efforts. In the document entitled "CPGs Approved in 2013", PHP specifies each CPG, its objective, source and relevance. The cited sources are evidence based or consensus of health professionals.	Full	Addressed in the QI Program Description, Purpose. Evidenced in the CPGs provided by Passport, which reference the source(s) for each guideline.	
consider the needs of Members;	Full- According to the Provider Manual, the intent of the guidelines is to support efforts in the care and education of members and to reduce variation in diagnosis and treatment. Guidelines are relevant to the needs of members, and QMMC and PCP	Full	As per onsite staff, data on the member population, particularly for co-morbid conditions, is reviewed annually to identify areas for guideline development. In the past couple of years, guidelines related to obesity and behavioral health	

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	Workgroup minutes reveal discussion of CPGs. As per onsite staff, population diagnoses, hospital readmissions and other data are reviewed to ensure the needs of members are considered in development of CPGs. An approval schedule and target for implementation is designated for each approved CPG.		conditions were adopted based upon members' needs, and respective disease management programs developed. Member educational materials are also developed in concert with the adopted guidelines.	
developed or adopted in consultation with contracting health professionals, and	Full- CPGs are approved by the QMMC and Partnership Council, which contain practitioners from a variety of disciplines. PCP Workgroup minutes reveal extensive discussion of CPG.	Full	Addressed in the QI Program Description, Appendix 1 – Committee Descriptions. Evidenced in QMMC and Partnership Council meeting minutes. Practitioners from a variety of disciplines are represented on both committees.	
reviewed and updated periodically.	Full- Each guideline is evaluated as new data becomes available or at a minimum of every two years. The Plan provided CPGs approved in 2012 and 2013.	Full	Addressed in QM 2.00 Clinical Practice Guidelines/Preventative Health Guidelines – guidelines are reviewed upon receipt of new scientific evidence or national standards or, at a minimum, every two years. Evidenced in the 2014 QI Work Plan and the QMMC meeting minutes. In addition, Activity Summaries present the guidelines to be reviewed and adopted or updated.	
Decisions with respect to UM, member education,	Full- P/P UM35 defines the processes	Full	Addressed in the 2014 UM and Clinical	

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covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.	utilized to evaluate a proposed treatment plan, appropriate location, level of care, and duration of service as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. A decision on which medical necessity is determined is based upon the application of recognized clinical criteria and internal medical policies. The Program Evaluation states that the purpose of the CPGs are to adopt, maintain, and implement preventive health guidelines that support ongoing early detection of illness and disease for the Plan's membership. Member education, such as member newsletters provided by the Plan, and care management programs are consistent with CPGs.		Programs Description. Evidenced in the QMMC and Partnership Council meeting minutes and in inter-rater reliability results for Utilization Management and in the 2014 QI Work Plan. The QI activities reference clinical guidelines in relation to interventions and education targeted at members and providers.	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.	Full- PHP has developed a tracking document ("innovate Program XLS") describing its innovative programs. The document includes such programs as: Pre-term Labor Prevention, Smoking Cessation and Pediatric Obesity. Also	Full	Passport provided a report of the Innovative Programs, in the areas of Pharmacy, Disease Management, E-Health Technology, and Other Areas.	

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	described are several innovative program initiatives related to the pharmacy program: telemedicine, e-Prescribing, Medical Therapy Management (MTM), polypharmacy and Increasing the usage of generic drugs. Program components and status are included in the report. **Recommendation for PHP** It would be helpful if the tracking document included dates of implementation, the rationale/justification for the program and the approving committee. The document includes the "responsible party" but by name only. The department responsible for the program is not specified. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by changing the program we use to document our Projects/Innovative Programs from the Excel spreadsheet to PIPE. PIPE stands for Project Intake, Prioritization & Evaluation. This process is more detailed than our previous documentation and includes a business case to be submitted to a PIPE			

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	Committee and to be approved at the Director level prior to moving to the Executive Leadership Team for final approval. The Business Case includes key topics including proposed project, submitter, strategic alignment, problem statement, project justification, project deliverables, organizational impact, cost benefit analysis, timeline, stakeholder analysis, resource requirements, and risk assessment. This business case is presented to the PIPE Committee and voted on using set criteria and scoring methodology. Once a project is approved, it is prioritized based on its score and the submitter enters into the online PIPE tool available on OurSpace. The submitter is responsible for weekly updates to the tool. The tool gives the viewer a high level overview of each project and the ability to click on an individual project for more detail. Included are several documents/screenshots.			

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	1-Business Case.docx Project Management Pr... PIPE Committee Charter.pdf PIPE screenshots.docx			

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	PHP-31.pdf			
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix N, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Full- PHP has prepared a document (2012 Health Outcomes and 2013 Member Satisfaction) highlighting its performance measure results. The document includes a description of the measure, trended performance and interventions to improve. Also included are goals for four measures. Onsite staff indicated that goals for measures are at the 90th percentile. **Recommendation for PHP** PHP may want to consider adding goals for the other measures or perhaps a global goal. **MCO Response:** Passport appreciates the recommendation by IPRO and will take it under advisement.	Full	Addressed in the QI Program Description, Purpose. Evidenced in the 2013 QI Evaluation – Quality Improvement Activities and Statutory Requirements and the 2014 QI Work Plan.	
Additionally, the Department, Contractor, and EQRO will	NA- On annual basis DMS in	Not Applicable	DMS has chosen not to rotate any	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	collaboration with the EQRO, evaluates the measures required for reporting. The measure set has been revised and refined. Plans are encouraged to provide input and have done so. To date, no measures have been rotated.		measures at this time... The performance measure set is reviewed annually by DMS and IPRO.	
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	Full- PHP reports four Healthy Kentuckian measures (state-specific): Height/Weight and BMI Assessment for Children and Adolescents, Height/Weight and BMI Assessment for Adults, Adolescent Screening/Counseling and Cholesterol Screening for Adults. Performance is trended over time and interventions for each measure have been identified to enhance performance. In addition, a performance measure specific to individuals with special health care needs (Children and Adolescents) has been developed and initiated.	Full	Measures for ISHCN were established and have been reported by the MCOs since reporting year 2013. In reporting year 2012, the EQRO calculated the rates.	
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- PHP met or exceeded the 2012 Quality Compass® 90th Percentile in nearly all sub-measures of Childhood Immunizations Status. 24 HEDIS measures increased by four percentage points or more, of which, 14 measures exceeds the 2012 Quality	Not Applicable	Due to the statewide expansion of the Kentucky Medicaid managed care program and addition of MCOs, rates were not trended and improvement was not assessed for 2014 because the rates were not comparable. A new baseline will be established.	

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	Compass® mean. For the Healthy Kentuckian measures: PHP reported an increase in several measures in measurement year 2012. For the Child and Adolescent measures, PHP demonstrated an increase in: -Documented Height/Weight -Healthy weight for Height -Nutrition Assessment/Counseling -Physical Activity Assessment/Counseling. BMI Percentile/Value decreased. For the Adolescent Screening measure, Mental Health Assessment/Counseling increased while Tobacco, Alcohol and Substance Abuse and Sexual Activity decreased. All of the Adult-related measures showed an increase from 2011 to 2012: Height/Weight, BMI Percentile/Value, and Healthy Weight for Height, Nutritional Assessment/Counseling, Physical Activity Assessment/Counseling and Cholesterol Screening.			

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The BMI and Adolescent measures that decreased are reflected in the 2013 QI Work Plan.			
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.	Substantial- Measures tracked and reported in the QI Program Evaluation have associated goals, most of which are quantifiable. Activities on performance measures are included in the QI Work Plan. The Performance Measure Healthy Kentuckian report includes goals for 4 measures. Onsite staff indicated that the Work Plan will be updated to include goals for all measures. Evidence of stratification of measures by eligibility, race, ethnicity and gender was not provided in pre-onsite documentation, but onsite staff demonstrated that these data are available. The Plan did not report measures by demographic subgroups. **Recommendation for PHP** The Plan should evaluate and report performance measures by eligibility, race, ethnicity and gender as feasible with available data to monitor	Minimal	DMS has chosen not to establish specific goal rates for the performance measures at this time. Passport set internal goals, most of which are quantifiable as reflected in the 2013 QI Program Evaluation. Monitoring and intervention activities for the performance measures are evidenced in the 2014 QI Work Plan. Evidence of stratification of performance measures rates by eligibility category, race, ethnicity and gender was not found in Report #96 submitted to DMS or with the pre-onsite documents. The report is limited to HEDIS measures; HK Performance measures are not included. During the onsite interview, Passport provided a document titled HEDIS 2014 Reported Measures for Effectiveness of Care and Access/Availability of Care, MCO Report #96 for Breast Cancer Screening that included results stratified by gender,	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by moving forward with 2014 rates, Passport will stratify each Healthy Kentuckian measure results by COA, race, ethnicity, gender and age in order to identify and alleviate any health disparities. We also stratify by Region in order to identify and alleviate any disparities. In addition, we stratify the non-compliant numerator members by servicing provider to provide education to the provider about the measure and ways to improve numerator compliance. Passport has updated the report for Healthy Kentuckians to include a goal column. We have utilized the 2014 Medicaid Quality Compass 90th percentile when appropriate; otherwise the goal is a 5% increase over the previous year's rate. See the attached report.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	disparities in care. **MCO Response:** Passport Health Plan respectfully disagrees with the Substantial finding and requests this element be re-reviewed for consideration of a Full Compliance finding. Passport completes the Report #96 Audited HEDIS- which includes the NCQA Final Audit Report, the IDSS, Historical Trending and the Stratification of key HEDIS measures. This report is due August 31 of each year. Passport is actively using the stratification breakdown to determine interventions aimed at improving HEDIS rates. The document is shared with the QI team, department leads for each measure, and the HEDIS workgroup. This year the stratification data will be added to the discussion factors during the HEDIS 2015 Brainstorming/Planning session. Final Review Determination: No change in compliance level. This review element relates to the Healthy Kentuckians Performance		eligibility category, race, ethnicity, and age. This element is scored Minimal because the prior year recommendation was not addressed. **Recommendation for Passport** Passport should evaluate and report stratified results of performance measures including HEDIS measures and non-HEDIS HK Performance Measures and set goals for each of these measures.	Performance Measure Reporting -

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Measures, which include, but are not limited to HEDIS measures. In addition, the report of stratified HEDIS results (#96) was not provided with the pre-onsite documentation or in conjunction with the onsite review. Additionally, based on the information provided on page 38 of this report, under 20.2 HEDIS Performance Measures, Passport Health Plan did not include the stratified rates in its submission of Report #96 to DMS. Passport Health Plan should evaluate and report the stratified results of the Healthy Kentuckians Performance Measures and proceed to set goals for each of these measures.			
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually .After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.	Full- PHP provided the HEDIS Final Audit Report, prepared by their HEDIS Licensed Audit Organization. All measures within the scope of the audit were deemed to be reportable. The Plan provided attestation of submission of the Final Audit Report (FAR) and IDSS to the Department.	Full	Includes review of MCO Report #96 Audited HEDIS Reports. Passport provided the HEDIS Final Audit Report, prepared by their NCQA-Licensed HEDIS Compliance Organization. All measures within the scope of the audit were determined to be reportable. Report #96 Audited HEDIS Report was	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			submitted as required with the Q3 2014 reports.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.	Full- The Performance Measure Healthy Kentuckian report trends measures over three years. Benchmark data and goals for four measures are provided.	Substantial	The HEDIS Final Audit Report and IDSS (Report #96) contain the eligible population, denominator, numerator and rates for all reported measures. Trending of results was not evident in the documents provided.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by including this trending data on an additional spreadsheet due to its size of including results from all previous years in both chart and table format. Both spreadsheets are submitted as part of Report #96. Report_96_HEDI... Historical HEDIS and QC Rates ...

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	Minimal- Evidence of stratification of measures by eligibility, race, ethnicity and gender was not provided in pre-onsite documentation, but onsite staff demonstrated that these data are available. The Plan did not report measures by demographic subgroups. **Recommendation for PHP** The Plan should evaluate and report performance measures by eligibility, race, ethnicity and gender as feasible with available data to monitor disparities in care. **MCO Response:** This is a required DMS Report # 96 which is an Annual Report due August 31st of each year. It was discovered in review of this finding, that the actual report was completed but not attached to last year's report. Passport has attached it for your review. Report_96_HEDIS2013_byCategory.xlsx	Minimal	Evidence of stratification of performance measures rates by eligibility category, race, ethnicity and gender was not found in MCO Report #96 submitted to DMS and with the pre-onsite documents. During the onsite review, Passport provided a document titled HEDIS 2014 Reported Measures for Effectiveness of Care and Access/Availability of Care, MCO Report #96 for Breast Cancer Screening that included results stratified by gender, eligibility category, race, ethnicity, and age. This element was scored Minimal because the prior year recommendation was not addressed. **Recommendation for Passport** Passport should report the stratified results of performance measures for all reportable Effectiveness of Care and Access/Availability of Care measures.	**Passport Response:** Passport Health Plan will provide the stratified measures for all reportable Effectiveness of Care and Access/Availability of Care measures in next year's report #96. See the attachments above.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in compliance level. As noted by Passport Health Plan, the stratified HEDIS results were unintentionally omitted from the submission of Report #96 to DMS and were not submitted with the compliance review documentation.			
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.	NA - The Plan reported all HEDIS measures with results as reported above; the Plan onsite staff did not report being required to implement a PIP. To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	Not Applicable	DMS has not chosen a specific subset of measures for performance evaluation. The performance measure set is reviewed annually by DMS and IPRO.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	NA- To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	Not Applicable	DMS has not chosen a subset of measures to be calculated using encounter data and used for evaluation of performance. The encounter data is not yet sufficiently accurate and complete to use for performance monitoring. The performance measure set is reviewed annually by DMS and IPRO.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The EQRO has conducted benchmarking studies to assess the comparability of HEDIS rates calculated by MCOs from claims data and those calculated by the EQRO using the data in the encounter data warehouse in an effort to assess and improve the validity of encounter data.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.	Full- A copy of the NCQA certificate and accreditation report was submitted. The Plan provided an attestation that documentation was submitted to the Department.	Non-Compliance	Passport received Commendable accreditation status effective 9/4/2014 through 9/4/2017. A copy of the NCQA accreditation certificate and report were submitted to the EQRO with the pre-onsite documents. No documentation of submission of the accreditation certificate and report to DMS was found. The certificate and reports were submitted to DMS on 3/18/2015 during the onsite review. **<u>Recommendation for Passport</u>** Passport should submit its current and	**Passport Response:** This was an oversight by the QI department to not send the NCQA Accreditation and certificate to DMS formally. To rectify this oversight, the QI team has developed a tracking tool for all required contractual submissions including the due date and what is required. This spreadsheet is monitored by the QI management staff.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			future certificates of accreditation with the complete accreditation survey reports to DMS as required.	
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 - PHP is NCQA accredited with "Excellent" status through 9/14.	Not Applicable	Passport is NCQA accredited with "Commendable" status through 9/2017.	
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 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.	Full- Two 2013 PIP proposals were submitted: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP). Ongoing PIPs for which reports were submitted in the review period include: Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections (Antibiotics PIP, proposal Aug 2012), Dental Care in Children with Special Health Care Needs (Dental PIP, proposal 9/1/2010), Reduction of Emergency Room Care Rates (Emergency Room PIP, proposal September 2011) and Smoking Cessation: Yes You Can! (Smoking Cessation PIP), for which a	Full	Includes review of MCO Reports: #19 PIPs #90 PIP Proposal #92 PIP Measurement Passport submitted the following PIPs in 2014: Proposals: Reducing Postpartum Readmissions and Statewide Collaborative - Use of Antipsychotic Medications for Children and Adolescents. Baseline Reports: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan and Psychotropic Drug Intervention Program. Final Reports: Reduction of Emergency Room Care Rates and Reduction of	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	follow-up analysis was submitted. The PIP topics are selected based on prevalence, high risk, high utilization and member need as documented in the PIP proposal rationales.		Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections. DMS has directed that the MCO conduct one behavioral and one physical health PIP annually. Passport supports the specific topics selected with a strong rationale, as seen in the PIP reports.	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the	Full- Two PIP proposals were submitted: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP), and there were several ongoing PIPs as documented above. The Performance Measure Healthy Kentuckian report demonstrates PHP's efforts to monitor its performance using HEDIS and state-specific measures. Interventions are included.	Full	Includes review of MCO Reports: #19 PIPs #90 PIP Proposal #92 PIP Measurement Passport submitted the following PIPs in 2014: Proposals: Reducing Postpartum Readmissions and Statewide Collaborative - Use of Antipsychotic Medications for Children and Adolescents. Baseline Reports: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan and Psychotropic Drug Intervention Program. Final Reports: Reduction of Emergency Room Care Rates and Reduction of	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.			Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections. DMS has directed that the MCO conduct one behavioral and one physical health PIP annually. Passport supports the specific topics selected with a strong rationale, as seen in the PIP reports.	
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full- A Health Department representative sits on the QMMC, and health departments and community organizations are represented on the Partnership Council. The QI Work Plan notes outreach and participation in community events and collaboration with community organizations. The PIP proposal for the Psychotropic Drug Intervention Program indicates that the MCO will collaborate with Beacon Health's Psychotropic Drug Intervention Program.	Full	A Health Department representative sits on the QMMC, and health departments and community organizations are represented on the Partnership Council. The QI Work Plan notes outreach and participation in community events and collaboration with community organizations.	
The Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures.	Full- PHP participated in teleconference calls with DMS, the Plans and the EQRO during the review period to evaluate opportunities and interventions. This	Full	Passport fully participates in and contributes to collaborative quality improvement efforts with DMS, the EQRO, government and community organizations	

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	includes, but is not limited to, discussion of monitoring and ensuring continued improvement for HEDIS measures and Healthy Kentuckian measures. The Plan participates in focused studies and PIP discussions with the Department and EQRO.		as evidenced in the 2014 QI Work Plan, the 2013 QI Evaluation and cooperation with EQRO activities.	
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 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.	Full- Two PIP proposals were submitted for 2013: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP). As noted above, there were several ongoing PIPs as well: the Antibiotics PIP (proposal August 2012), Dental PIP (proposal 9/1/2010), Emergency Room PIP (proposal September 2011) and Smoking Cessation PIP. Each PIP presents a rationale for the topic selection that includes prevalent and high risk/high utilization conditions, need for coordination, and/or preventable complications and utilization.	Full	Passport submitted the following PIPs in 2014: Proposals: Reducing Postpartum Readmissions and Statewide Collaborative - Use of Antipsychotic Medications for Children and Adolescents. Baseline Reports: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan and Psychotropic Drug Intervention Program. Final Reports: Reduction of Emergency Room Care Rates and Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections.	
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	NA- The Plan is conducting PIPs as above, with topics approved by the Department.	Full	The PIPs conducted by Passport are consistent with the topics provided by DMS in the contract and are approved by	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 Other Regions contract			DMS as evidenced by the approval signatures on the PIPs' Attestation pages.	
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- PHP is reporting PIPs using the template provided by the state.	Full	Passport uses the EQRO-provided template, including updated versions as issued.	
A. Topic and its importance to enrolled members;	Full- Each PIP proposal includes a discussion of the PIP topic and rationale, including its relevance to Plan membership.	Full	Each of the PIP topics is substantiated by a rationale supported with literature citations and data and demonstrates relevance to the membership.	
B. Methodology for topic selection;	Full- Each PIP proposal includes a discussion of the PIP topic and how it was selected. For example, the ED PIP included analysis of MCO data and performance, and the Dental PIP included a discussion of Healthy Kentuckian performance and the significance of this issue in Kentucky.	Full	Each PIP report includes a data driven rationale and logical decision-making for the topic selection.	

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	PIPs are discussed in QMMC committee as evidenced by committee minutes.			
C. Goals;	Full- The Plan's submitted PIP proposals include goals.	Full	Passport sets goals for each of its PIP indicators and supports the goals with a rationale (e.g., Quality Compass percentile benchmark).	
D. Data sources/collection;	Full- Each submitted PIP proposal includes data sources and collection methodology.	Full	The PIP proposals and reports include a description of the methodology, including indicators, data source and data collection methods and efforts to ensure validity and reliability of the data. In some instances the indicators need refinement. Passport is receptive to EQRO input.	
E. Intervention(s) – not required for projects to establish baseline; and	Full- Each PIP proposal includes an outline of interventions. Most proposals include multifaceted, active interventions. The Antibiotic PIP includes robust provider interventions but could include more active member interventions as noted in PIP review comments.	Substantial	Passport generally develops multifaceted intervention strategies that address members, providers and the health plan systems. In some cases, interventions may be passive and in some instances, the intervention descriptions need more detail. **Recommendation for Passport** Passport should ensure that active, targeted interventions are implemented for each PIP and that the interventions are described in detail in the PIP report.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendations for each of the active PIPS by actively working to include more detail for each intervention both planned and completed as suggested. Passport strives for constant quality improvement in the health care our member's receive. As a result, we have hired a new VP of Clinical Performance to implement a new Business Intelligence platform to allow for more robust reporting of quality of services both retrospectively and prospectively. Implementation is

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				targeted for 1st qtr 2016. Passport utilizes the techniques of PDSA to conduct our PIPs with input from all departments within the health plan. Passport also would welcome feedback from IPRO during the development stage of each PIP to focus our efforts in the most productive methodology. **DMS Response** The new Vice President of Clinical Performance was named and start date as March 2015.
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.	Substantial- Each PIP report includes results and interpretation. For some PIPs, the lack of improvement was attributed to an influx of new members only and there did not appear to be an analysis of interventions (CSHCN Dental, ED Utilization). **Recommendation for PHP** The Plan should ensure that interventions are re-evaluated and a plan of action developed for PIPs that do not demonstrate improvement. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation	Full	Passport presents PIP results clearly in tables and graphs. In some cases, suggestions on how to display the data are provided by the EQRO. There are 2 PIPs with final remeasurement results: Reduction of Emergency Room Care Rates – this PIP did not demonstrate improvement at interim or final re-measurement. The overall score earned was 72.5 of 100 points. Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections – this PIP	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and has initiated this activity with the dental care for children with special health care needs.		demonstrated improvement at both interim and final re-measurement. The PIP earned a final score of 92.5 of 100 points.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Full- Final PIP reports include a member confidentiality statement.	Full	Both final PIP reports met this requirement.	
B. Did Members participate in the performance improvement project;	Full- This is addressed in the final reports.	Full	Both final PIP reports met this requirement.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	Full- This is addressed in the final reports.	Full	Both Final PIP reports met this requirement.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;	Substantial- As per the PIP final report, results and conclusions were to be presented to QMMC and QMAC. **Recommendation**: The Plan should make results and conclusions of PIPs available to members, providers and any other interested bodies; the Plan should clarify how this will be done in policies and procedures. **MCO Response:** Passport Health Plan	Minimal	Passport revised its Policy and Procedure QM 19.00 Performance Improvement Projects to include QMMC and QMAC review and approval of PIPs. In the QMMC meeting minutes, there is only discussion of the Dental Care and Smoking Cessation PIPs at the October meeting and a general mention of PIPs as a component of the QI Work Plan in September 2014. There is no documentation in the QMAC meeting minutes of review of PIP reports,	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by implementing additional reporting related to PIPs to the QMMC committee to include quarterly updates on all the active PIPs as well as the annual summaries. See attached May QMMC agenda

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
	has acted upon IPRO's recommendation by revising policy QM 19.00 to address the results and conclusions of PIPs available to members, providers and any other interested bodies. The annual summary and/or final report will be presented to QMMC and QMAC after they are approved by DMS and IPRO. QM 19.00 Performance Improve		findings and conclusions. The Policy and Procedure does not describe how results and conclusions of PIPs will be made available to other interested bodies. During the onsite review, Passport indicated that the MCO intends to post a PIP update/summary to its website pending the website conversion currently in process. The expected completion date is Q2 2015. **Recommendation for Passport** Passport should ensure that PIP activity summaries and final reports are presented to the QMMC and QMAC as stated in the Policy and Procedure and that this is documented in the meeting minutes. Passport should develop or revise and implement a Policy and Procedure to address making results and conclusions of PIPs available to other interested bodies.	C. Agenda.doc As per the policy QM19.00, QMAC will review and make recommendations to the annual summary and/or final results. Feedback will be requested with this year's report on the frequency they would like updates. Policy QM 19.00 has been updated to include the QMMC quarterly and annual reports as well as the annual and/or final results being posted to the Passport website for review by any interested parties. The website posting will be implemented with the September 1, 2015 reports. See QMMC October 2014 agenda B QMMC Agenda October 2014.do...

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**
				QM 19.00 Performance Im...
E. Is there an executive summary;	Full- The final report includes an abstract.	Full	For final reports, an abstract is prepared, as required.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	Full- Information is clearly presented in final PIP reports.	Full	Passport prepares tables and graphs for PIP data that are clear. Where clarifications are suggested by the EQRO, Passport implements the suggestions.	
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement	Full- Submitted PIPs utilize HEDIS measures and in some cases modified HEDIS measures and goals are identified.	Full	Evidenced in the PIP reports where national Medicaid benchmarks are used for PIP indicators based on HEDIS and CAHPS measures. The results are graphed with rates trended and goals/benchmarks indicated.	
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data	Full - Final reports include evaluation for sustained improvement; calculation	Full	The final reports include a measurement for sustained improvement.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	of HEDIS measures utilized in the PIPs is ongoing.		Annual HEDIS performance reporting ensures ongoing monitoring for PIPs that focus on HEDIS indicators.	
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- Addressed - Two PIP proposals were submitted on 8/30/2013 (You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP).	Full	Passport submitted its proposals timely in September 2014.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	Full- The Antibiotic PIP interim (baseline) report was submitted 8/30/13, within one year of proposal.	Full	Passport submitted its baseline PIP reports timely in September 2014.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	Full- Interim report for the ED Utilization PIP was submitted 8/30/13, within two years of baseline year.	Not Applicable	Passport did not have any interim PIP reports to submit for the period September 2014.	
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	Full - The final PIP report for the Dental PIP was submitted 8/30/13, within one year of first remeasurement.	Full	Passport submitted its final PIP reports timely in September 2014.	
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	Full - PHP's Quality and Member Access Advisory Committee (QMAC) meets every two months and at least four times a year.	Full	Includes review of MCO Report #21 MCO Committee Activity. Addressed in the 2014 QI Program	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
interests of the Member population.	The QMAC includes members and parents of members, consumer advocates, and educators and considers geography, gender, age, Aid Category, race and ethnicity when selecting members. Members with disabilities and the aged as well as members representing children with special needs are also represented.		Description, Appendix 1 – Committee Descriptions. Passport's QMAC met four times in 2014. Meeting minutes reveal that committee members include representatives and advocates for foster children, CSHCN, disabled people, people with mental illness, homeless people, community organizations, members, parents of members, and grandparents raising grandchildren.	
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 - Geography, gender, age, Aid Category, race and ethnicity are all factors that are considered when selecting representatives for the committee. The Plan has been successful in engaging members to participate in committees.	Full	A wide variety of member advocacy groups and populations are represented in the committee. The MCO has been successful in engaging members to participate in committees.	
A. Providing review and comment on quality and access standards;	Full - Minutes of the February 2013 QMAC meetings indicate a discussion about PHP's provider access and availability reports. Other topics of discussion reflected in QMAC minutes include Care Management, Appeals, Member Satisfaction, PIPs, QI Program Evaluation and EQRO.	Full	Minutes of the 2014 QMAC meetings indicate a discussion about Passport's provider access and availability reports.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 - Minutes of the 2013 QMAC meetings indicate a discussion about member appeals and grievances.	Full	Minutes of the 2014 QMAC meetings indicate a discussion about member appeals and grievances.	
C. Providing review and comment on Member Handbooks;	Full- QMAC policy indicates that the QMAC reviews Member Handbooks. Onsite staff provided QMAC minutes from that reflected mailing of the Member Handbook to committee members in November 2013, with email vote to approve the document.	Full	Policy and Procedure directs that the QMAC review Member Handbooks. The December 2014 QMAC minutes reflect discussion and approval of the Member Handbook.	
D. Reviewing Member education materials prepared by the Contractor;	Minimal- Other than QMAC policy that indicates the committee reviews Member Handbooks, there was no evidence that member educational materials were reviewed in the minutes provided. **Recommendation for PHP** The Plan should ensure that member education materials are reviewed by QMAC. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by having member materials taken to QMAC for feedback as part of the development process when initiating new member material.	Full	Policy and Procedure CC 27.01 Development and Approval of Member Educational Material was revised to include review of newly developed member education materials by the QMAC. The QMAC Charter dated 12/18/14 addresses review of member educational materials and the Member Handbook. The QI Program Description, Appendix 1 – Committee Descriptions also addresses review of member educational materials. The 2014 QMAC meeting minutes reflect review of member educational materials.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	CC 27 01 Development and Appr IPRO Comment: Note that there is no revision date on the P/P to reflect the addition of the highlighted text. In addition, during the next annual compliance review, QMAC minutes will be reviewed to assess if the P/P has been implemented.			
E. Recommending community outreach activities; and	Full- The October 14, 2013 minutes include discussion of two large community engagement events: Healthy Hoops Kentucky and The Fall Safari for Grandparents raising Grandchildren.	Full	QMAC and Partnership Council minutes include discussion of the Have Faith in Hearts Program. A community engagement update is provided at each QMAC meeting.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full- QMAC minutes include documentation that the committee reviewed member grievances and appeals, access and availability studies, case management activities, and contract management reports.	Full	QMAC minutes include documentation that the committee reviewed member grievances and appeals, access and availability studies, case management activities, and contract management reports.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full- QMAC minutes include members that attended and members who were excused from the meeting.	Full	QMAC minutes include members that attended and members who were excused from the meeting as well as their role/title	

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**
			(e.g., member, community advocate, organization).	
20.8 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 its annual member CAHPS survey and provider satisfaction survey. A CAHPS report and PowerPoint presentation were submitted.	Full	Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys. Passport submitted Reports #94 and #95 which included the survey instruments for CAHPS Child and Adult Surveys and Provider Satisfaction. Results for each survey were also submitted. Finding from the CAHPS surveys were as follows: Adult CAHPS – A decline for Rating of Specialist and Coordination of Care rates between 2013 and 2014 was statistically significant. Four measures met the 90th percentile: Getting Care Quickly, Getting Needed Care, Customer Service and Rating of Health Plan. How Well Doctors Communicate ranked in the 75th percentile. Less strong results were seen for Rating of Specialist (50th), Rating of All Health Care (25th), Personal Doctor (25th).	

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**
			Child CAHPS – There were no statistically significant changes in rates between 2013 and 2014. The following ranked in the 90th percentile: Getting Care Quickly, Getting Needed Care, Rating of All Health Care, Rating of Specialist and Rating of Health Plan. How Well Doctors Communicate and Customer Service both ranked in the 50th percentile.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full- The 2013 CAHPs report prepared by Morpace, an NCQA-certified CAHPs vendor was submitted.	Full	Passport submitted copies of the CAHPS surveys to DMS. The 2014 CAHPs report prepared by Morpace, an NCQA-certified CAHPs vendor was also submitted.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	Full- The report reveals that one supplemental question was added to CAHPS: Q26a. How important is it that Passport Health Plan reminds you that it is time for your child to see his or her doctor for care? P/P BH 17.0 outlines procedures for the DCBS population survey, and examples of the survey were provided by the Plan. The Plan has also developed a Case Management satisfaction survey as outlined in P/P CC 25.01.	Full	Passport conducts case management and disease management satisfaction surveys.	

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 meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Full- PHP submitted a PowerPoint presentation presenting the results for its 2012 Practitioner Satisfaction Survey. The 2013 Practitioner Survey was conducted in the fall of 2013, with results to be analyzed in first quarter 2014. The Plan provided attestation that the provider survey was submitted to DMS.	Full	The provider satisfaction survey instrument was submitted to DMS with the Q3 2014 reports. Passport submitted a PowerPoint presentation displaying the results for its 2014 Practitioner Satisfaction Survey. The survey asked about: the courtesy, promptness and knowledge of provider services staff, claims processing, familiarity with the pharmacy benefits, and use of the NaviNet platform, referrals, availability of specialist, appeals, prior authorization, and the provider website. Overall, 96% of providers surveyed were satisfied or very satisfied with Passport.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	Full- The Plan provided attestation of submission of survey reports to the Department.	Full	Passport submitted reports for the Adult and Child CAHPS surveys and the 2014 Provider Satisfaction Survey, Report #96 with the quarterly reports. The survey instruments for each were also submitted with Report #94 and #95.	

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**
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full- The Plan provided attestation of submission of survey reports to the Department. Results are presented to QMMC and QMAC, and there is reference to member survey on the Plan website.	Full	Passport submitted the member and provider survey results to DMS as required. For members, the QMAC reviews the Annual QI Evaluation, which contains the results of the CAHPS surveys and the Provider Satisfaction Survey.	
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 Plan provided attestation of submission of quarterly reports.	Full	Quarterly QI Work Plan updates were submitted to DMS, Report #17, as required. In addition, the annual QI Evaluation was submitted, Report #85.	

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	92	3	3	1
Total Points	276	6	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		**2.88**		

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' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

QI Program Description
QI Work Plan
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports
Quality Improvement Committee description, membership, meeting agendas and minutes
Committee description, membership, meeting agendas and minutes for QMAC
Clinical Practice Guidelines
Provider Manual
Provider Newsletters
Provider Committee minutes
Innovative Program description and status report

Reports

Annual QI Evaluation Report
HEDIS Final Audit Report and IDSS rates
Healthy Kentuckians Outcomes Measures Report
CAHPS Report
Provider Satisfaction Survey Report
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Performance Measure Reporting
Evaluation, analysis and follow-up of performance measure results
Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines
Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of services

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

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
24. General Requirements for Grievances and Appeals				
The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B.	Full-2014			
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf. KAR 17:010 Section 4 (18)	Full-2014			
24.1 Grievance and Appeal Policies and Procedures				
The MCO shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in accordance with 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. These policies and procedures shall include, but not be limited to:	Full-2014			
A Member may file a grievance either orally or in	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member. KAR 17:010 Section 4 (2), (4) (a) and Section 15 (1)				
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-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
A. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	New Requirement	Full	Addressed by MS 16.0 Grievance Intake Process – Procedure section 16.d (page 4). Passport analysis of 2013 grievances led to interventions including revisions to the welcome call scripts; and implementation of weekly responsibility rotation for special support technicians.	
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	Minimal	Policy and Procedure PHP 20 Record Retention Guidelines does not address grievance files. During the onsite review, Passport updated this policy to include grievances and appeals as examples of records to be retained. Although the policy instructs departments to review the state and federal requirements for record retention in their respective area, the policy should also address maintenance of grievance files separate from medical case records and in a manner which protects the confidentiality of members who file a grievance or appeal. **<u>Recommendation for Passport</u>** Passport should update the policy to include maintenance of grievance files separate from medical case records and in a manner which protects the confidentiality of members who file a	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy PHP 20 – Record Retention Policy, which specifically includes the maintenance of grievance files separate from medical case records. PHP 20 - Record Retention Policy.pdf

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**
			grievance or appeal.	
C. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full-2014		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
D. If the grievance involves a Medical Necessity determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;	Full-2014		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
E. Process for informing Members, orally and/or in writing, about the MCO's Grievance and Appeal Process by making information readily available at the MCO's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Full-2014			
F. Provide assistance to Members in filing a grievance if requested or needed;	Full-2014			
G. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Full-2014			
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.	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
42 CFR 438.410 (b)				
H. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Full-2014			
I. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Full-2014		Includes Member Grievance Random and Member Grievance Quality file review results	
J. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	New Requirement	Full	The following documents meet the requirement: MS 24.0 Member Appeals – Member Services, CP 5.20 Member Appeals and 2014 Utilization Management and Clinical Programs Description section XII Appeals pages 28-31.	

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**
K. Provide for continuation of services, if appropriate, while the appeal is pending; The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420	Full-2014			
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member;	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
(4) The time period or service limits of a previously authorized service has expired. 42 CFR 438.420 KAR 17:010 Section 4 (14)				
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420	Full-2014			
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			
L. Provide expedited appeals relating to matters	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
which could place the Member at risk or seriously compromise the Member's health or well-being; If the Contractor denies a request for an expedited resolution of an appeal, it shall: (1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and (2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file. KAR 17:010 Section 4 (16)				
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			

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**
O. Provide for continuation of services, if appropriate, while the hearing is pending. The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420	Substantial- This requirement is addressed in P/P CP 5.20. The policy states that the notice shall conform to the requirements of KRS 13B.050(3)(d) and (e). This policy states that benefits will continue if the member requests a state fair hearing within 30 days of an action. This information is also included in notice of action as per P/P UM 11.01. The template letter for members whose appeal was upheld indicates that members will not lose benefits if they request a fair hearing. Other member documents refer to right to request receipt of benefits while appeal is pending but not explicitly while state fair hearing is pending. The plan indicated onsite that this is applicable, since the state fair hearing is a form of appeal. **Recommendation for PHP** The plan should clarify that member rights to request continuing benefits pending appeal applies to all appeals, including state fair hearing. **MCO Response:** Passport agrees with the recommendation and has updated CP 5.20, #4 and UM 11.01, #7m	Full	The following documents meet the requirement: CP 5.20 Member Appeals page 3 and 2014 Utilization Management and Clinical Programs Description section XII Appeals pages 28-31.	

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**
	CP 5 20 Member Appeals with 2013 DM UM 11 01 Denial of Services (2).docx IPRO Comment: Passport Health Plan should ensure that this Information is communicated to Providers and Members.			
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member; (4) The time period or service limits of a previously authorized service has expired.	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
KAR 17:010 Section 4 (14) 42 CFR 438.420				
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420	Full-2014			
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)	Minimal- P/P UM 30.0 Confidentiality and Privacy addresses this requirement, and described locked files for paper records and scanning and maintaining files electronically. This policy indicates that denials	Minimal	UM 30.0 Confidentiality and Privacy Guidelines – Utilization Management Department page 1 states "all medical records, in any medium, related to the	**DMS Response** This will be a Minimal Review Determination for March 2015. Was a

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**
years following the final decision by the Contractor, an administrative hearing officer, judicial appeal, or closure of a file, whichever occurs later.	will be retained for 7 years following final decision or closure. The policy does not address grievance files specifically. **Recommendation for PHP** The plan should ensure that policies and procedures reflect the requirement that files be maintained for 10 years not 7 years, and address grievance files. **MCO Response:** Passport Health Plan has acted upon IP recommendation by revising Policy UM 30.0, Confidentiality and Privacy Guidelines – Utilization Management Department, to include 10 years, not 7 years. See page 4. UM 30 0 Confidentiality and Pri IPRO Comment: The P/P addresses this requirement relative to appeal files. Passport Health Plan also needs to take action to ensure that this requirement is addressed in P/P relative to grievances.		Utilization Management process are maintained in a secure environment for a minimum of 10 years following the final decision by Passport, the Department of Medicaid Services, an administrative law judge, judicial appeal, State Hearing or closure of a file, whichever occurs later." Page 5 states that "denials are retained electronically for a period of 10 years". This requirement is also addressed in CC 22.0 Confidentiality, Privacy and Disclosure Guidelines for Care Coordination. Neither policy specifically addresses maintenance of grievance files. **Recommendation for Passport** Passport should either update this policy or develop a policy that addresses these requirements for grievance files.	Minimal for last year. Minimal Review Determination this year due to the information from Prior Results & Follow-up regarding the grievance files and IPRO Comments and Recommendation page 12 regarding these files. This may receive a LOC. **Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy PHP 20 – Record Retention Policy, to specifically address grievance and appeals files. PHP 20 - Record Retention.pdf
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	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.				
Documentation regarding the grievance shall be made available to the Member, if requested.	Minimal- P/P MS 16.0 indicates that information considered in resolution of the grievance is provided in resolution letters. Grievance and appeal policies and procedures do not otherwise address making documentation regarding the grievance available to members if requested. Onsite staff indicated that there are formal procedures for members requesting records in general. **Recommendation for PHP** The plan should reference procedures for members requesting documentation related to grievances including routing such requests to other departments, in grievance and appeals policies and procedures. MCO Response: Passport Health Plan respectfully disagrees with this finding. Procedures for members requesting Protected Health Information are provided in Policy PHP23, Member Right of Access to Protected Health Information, starting on page 6, which was provided to IPRO onsite while at Passport.	Full	The following documents meet the requirement: Member Handbook page 34 states "you may get free copies of any documents related to your appeal or copies of any information we used to decide medical necessity. You must ask for them in writing." Member Rights & Responsibilities page 28 states that the member has the right to "look at and get a free copy of your medical records, as permitted by law." MS 16.0 Grievance Intake Process page 5 states "Grievance documentation will be shared in accordance with Passport Policy PHP 23, Member Right To Access to Protected Health Information".	

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**
	PHP 23 - Member Right of Access to Pro Final Review Determination: No change in compliance level. The P/P provided is general and does not specifically address the Member right to access grievance documentation. Passport Health Plan should include this right in its P/Ps for grievances and may reference that grievance documentation will be shared in accordance with P/P PHP 23 Member Right of Access to Protected Health Information. Additionally, Passport Health Plan should ensure that this information is communicated to Providers and Members.			
Grievance File Review				
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution. KAR S 17:010 Section 4 (2) (a)	Full-2014		Includes Member Random and Member Quality Grievance file review results	

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 investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	Full-2014		Includes Member Random and Member Quality Grievance file review results	
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. 42 CFR 438.408 (c)	Full-2014		Includes Member Random and Member Quality Grievance file review results	
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	Full-2014		Includes Member Appeal file review results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)				
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 timeframe. KAR 17:010 Section 4 (11) and (12)	Full-2014		Includes Member Appeal file review results	
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)	Full-2014		Includes Member Appeal file review results	
The Contractor shall provide the Member or the	Full-2014		Includes Member Appeal file review	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
representative 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)			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. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Full-2014		Includes Member Appeal file review results	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the	Substantial- This requirement is addressed in CP 5.20. This information is communicated to members for appeals in general in the Member Handbook and final appeal decision upholding action letter, but not specifically for a state hearing, which is a type of appeal.	Full	Includes Member Appeal file review results The following documents meet the requirement: CP 5.20 Member Appeals, Member Handbook pages 34-35 and 2014 Utilization Management and	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
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)	Appeal File Review All reviewed files not resolved wholly in the member's favor included information regarding continuation of benefits. **Recommendation for PHP** The plan should clarify that member rights to request continuing benefits pending appeal applies to all appeals, including state fair hearing. **MCO Response:** Passport agrees with the recommendation and has updated CP 5.20, #4 and UM 11.01, #7m CP 5 20 Member Appeals with 2013 DM UM 11 01 Denial of Services (2).docx IPRO Comment: Note that this particular requirement relates to the Member being liable for the cost of benefits provided during appeal/SFH if the SFH uphold's the MCO decision. P/P CP 5.20 Member Appeals, page 3, item #4 addresses this by stating: "If final decision is adverse to member, the		Clinical Programs Description section XII Appeals pages 28-31. File review was deemed for 2015.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	member may be required to pay for services provided while the appeal was pending." Passport Health Plan should revise the wording to include the word 'provided' as noted above. Passport Health Plan should update P/P UM 11.01 Denial of Services to include this statement. Additionally, Passport Health Plan should ensure that this information is communicated to Providers and Members.			
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-2014		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 extension not requested by the Member, the Contractor shall give the Member	Full-2014		Includes review results for Member Appeals if expedited	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
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)	Substantial- This requirement is addressed in CP 5.20. The Member Handbook and Notice of Action indicate that resolution for expedited appeals is within 72 hours. Language does not specifically state the limited time available for the member to present evidence and allegations. **Recommendation for PHP** The Member Handbook and Notice of Action should explicitly inform the member of the limited time available for the member to present evidence and allegations for expedited appeals. **MCO Response:** Passport agrees with the recommendation and has updated the Notice of Action, Attachment A to UM 11.01. The Member Handbook will be updated at the next review. UM 11 01 Denial of Services (2).docx IPRO Comment: Passport Health Plan should provide the	Full	Includes review results for Member Appeals if expedited The following documents meet the requirement: CP 5.20 Member Appeals, Member Handbook pages 33-34 and 2014 Utilization Management and Clinical Programs Description section XII Appeals pages 28-31.	

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**
	revised Handbook to DMS for review and approval once the revision is completed.			
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-2014			
27.8 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that all appeals from Providers are reviewed. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. Appeals received from Providers that are on the Member's behalf with requisite consent of the	Full-2014		Includes file review summary results for Provider Grievances and Provider Appeals Includes review of MCO Reports: #27 Grievance Activity	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
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.			#28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results)	
27. 9 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they	Full-2014			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
enter into a contract.				
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) MCO Reports #27, 28 and 29 reported quarterly. IPRO findings are communicated to the MCO in the quarterly desk audit reports. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals were addressed by PHP. **<u>Recommendation for Passport</u>** IPRO recommendations regarding grievance reports include: 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. Narrative report (#29) should include total # of member grievances received, total # resolved and # and	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating the Quarterly Desk Review. IPRO's Quarterly Desk Review.docx

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**
			percent of grievances resolved within 30 days of receipt.	
The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.	New Requirement	Full	Addressed in QM 16.00 Practitioner Office – Site Visits Related to Member Complaints.	

Final Findings

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	7	1	2	0
Total Points	21	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		**2.5**		

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

Reviewer Decision:

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

Final Findings

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

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

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: Passport Health Plan

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.	Full-2014			
The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's 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.	Full-2014		Includes HRA file review results	
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.	Substantial- Health Risk Assessment (HRA) Management Policy No. CC 2.00 includes reasonable efforts to contact members (telephonic, by mail and\or in person) as per contract language. While the policy indicates that telephonic outreach can be live or automated, there is no specificity regarding when members are identified for in person outreach. Onsite staff indicated that members	Substantial	Includes HRA file review results The MCO provided a spreadsheet showing the initial and follow-up contact attempts, including the method used, e.g., postcard, phone call. Policy CC 2.00 Health Risk Assessment (HRA) Management was revised during the onsite	**DMS Response** If this Policy is not finalized and MCO receives a Substantial next year for 2016 Annual Compliance Review, there may be a possibility of a CAP.

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**
	without phones are targeted for in person outreach. Two of the four successful HRAs in the reviewed file included in-person outreach. Specific outreach procedures were described by onsite staff, who indicated that the initial outreach attempt is a new member mailing, conducted when the plan becomes aware of the enrollee. The plan conducts outreach calls 15 days later and then a third attempt (reminder postcard) after the next 15 days if there is no response, in order to ensure completion within 90 days. HRA File Review All reviewed files included evidence of outreach within specified timeframes above. Onsite staff indicated that initial outreach is the new enrollee mailing, which includes an HRA, although this attempt is not currently included in the tracking database. Onsite staff provided a summary of initial mailings for the file sample; this information was maintained separately. A total of 18/20 files contained evidence of two additional outreach attempts. Two files had documentation of only initial mailing and one additional mailing; onsite staff indicated that one of these members had no phone. The other member had a notation of a chronic condition in the file. **Recommendation for PHP**		review to clarify when in-person attempts are initiated. Members without telephone numbers may be outreached by the MCO's embedded case management team for an in-person attempt. HRA File Review Results A total of 25 files were reviewed. 23/25 files included evidence of a timely initial outreach attempt. The remaining 2 files had no attempts documented. Of the 23 files showing an initial attempt, 21 had evidence of at least 2 additional outreach attempts. 2 files had only one additional outreach attempt. **Recommendation for Passport** The revisions to Policy CC 2.00 should be finalized. Passport should ensure that initial outreach is attempted for new enrollees and that at least 2 follow-up attempts are made in accordance with the MCO policy. **Recommendation for DMS** DMS may want to consider developing, in consultation with the MCOs, either: a standardized HRA tool for use across MCOs, or a list of minimally required contents for MCO-specific HRA tools. DMS may also consider specifying in the MCO contract, the minimum number of outreach attempts and the types of methods	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy CC 2.00 Health Risk Assessment (HRA) with additional information regarding a third attempt for members without a phone available. CC 2 00 Health Risk Assessment... In addition, Passport is diligently investigating options to improve the entire process of the HRA from start to finish better assessing and assisting our member's needs timely, accurately, and effectively. Passport has identified a solution/partner that will allow for the HRA process to be electronic and plan to implement this solution.

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**
	The plan should include initial contact attempt in tracking database, and clarify policy/procedures regarding when in-person attempts are initiated, e.g. for members with no phone. **MCO Response**: Passport acknowledges the recommendations.		to be used, such as at least 3 outreach attempts using at least 2 different methods.	
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.	Substantial- This requirement is addressed in CC 2.00, which includes the Adult Health Risk Assessment Form and the Pediatric Health Risk Assessment Form. HRA File Review All three of the completed HRAs reviewed included all appropriate information. The plan was unable to locate the electronic HRA for the fourth member with a completed HRA, although documentation indicates that the member was referred to Mommy Steps for further assessment and management. **Recommendation for PHP** Completed HRAs should be available for review. **MCO Response:** Passport agrees with the recommendation.	Substantial	Includes HRA file review results HRA File Review 5/25 members contacted completed an HRA. All 5 HRAs were provided for review. All components were addressed with the exception of: One file for a member with multiple health issues. The member did not answer several questions related to their PCP. No referral was made but appears indicated based upon the member's history and possible gaps in care. **Recommendation for Passport** Members with documented medical problems and potential gaps in care should be referred for follow-up.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy CC 2.00 Health Risk Assessment (HRA) with additional information regarding a third attempt for members without a phone available. In addition, Passport is diligently investigating options to improve the entire process of the HRA from start to finish, better assessing and assisting our member's needs timely, accurately, and effectively. Passport has identified a solution/partner that will allow for the HRA process to be electronic and plan to implement this solution. Please see Policy CC 2.00 - Health Risk Assessment, attached above.

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**
The Contractor shall use appropriate healthcare professionals in the assessment process.	Substantial- CC 2.00 does not specify the role of health professionals in the assessment process, although there is reference to follow- up and intervention by care coordination staff (health management, disease management, and case management) for members needing immediate case or disease management assistance. How members are identified to have such immediate need is not explicit in P/P CC 2.00. Onsite staff indicated that the care coordination staff identified in Policy 2.00 is health professionals. **Recommendation for PHP** The plan should clarify the role of healthcare professionals in the assessment process in policies/procedures. **MCO Response:** Passport acknowledges the recommendations.	Full	Completed HRAs are reviewed by case management technicians. Member identified as needing immediate assistance are referred to Passport's Rapid Response or Case Management staff for follow-up.	
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.	Substantial- This requirement is addressed in CC 2.00, section 7.B. Representatives assist members by completing the HRA form telephonically. During the outreach call the Representatives offer members assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions. HRA File Review All (3/3) files with completed HRAs included	Substantial	HRA File Review 4 of 5 files with completed HRAs included assessment of need for assistance with arranging an initial visit with their PCP. One file for a member with multiple health issues. The member did not answer several questions related to their PCP. No referral was made but appears indicated based upon the member's history and possible gaps in care. **Recommendation for Passport** The MCO should ensure that all members	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy CC 2.00 Health Risk Assessment (HRA) with additional information regarding a third attempt for members without a phone available. In addition, Passport is diligently investigating options to improve the entire process of the HRA from start to finish better assessing and assisting our

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**
	assessment of need for assistance with arranging an initial visit with PCP; the file of one member indicated that assistance was needed in scheduling an appointment but there is no evidence in the file that this assistance was provided. **Recommendation for PHP** The plan should ensure that all members indicating a need for assistance with PCP visits are provided assistance. **MCO Response:** Passport agrees with the recommendation.		indicating a potential need for assistance with PCP visits are provided assistance.	member's needs timely, accurately, and effectively. Passport has identified a solution/partner that will allow for the HRA process to be electronic and plan to implement this solution. Please see Policy CC 2.00 - Health Risk Assessment, attached above.
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.	Full-2014		Includes review of MCO Report #79 Health Risk Assessments	

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

Health Risk Assessment

Scoring Grid:

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

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

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: Passport Health Plan

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.2 Provider Credentialing and Recredentialing				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,	Full-2014			
defining the scope of providers covered,	Full-2014			
the criteria and the primary source verification of information used to meet the criteria,	Full-2014			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Full-2014			
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialling of providers.	Full-2014			
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.	Full-2014			
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists,	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
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-2014			
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.	Full-2014			
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full-2014			
C. A review of the credentialing policies and procedures by the formal body;	Full-2014			
D. A credentialing committee which makes recommendations regarding credentialing;	Full-2014			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full-2014			
F. Written procedures for the termination or suspension of Providers; and	Full-2014			
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Full-2014			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of	Full-2014		Includes Credentialing file review summary results	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Providers credentials shall include the following:				
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Full-2014			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full-2014			
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	Full-2014			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full-2014			
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-2014			
F. Previous five (5) years work history;	Full-2014			
G. Professional liability claims history;	Full-2014			
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Full-2014			
I. Current, adequate malpractice insurance, as verified	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
through attestation;				
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full-2014			
K. Documentation of curtailment or suspension of medical staff privileges;	Full-2014			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full-2014			
M. Documentation of censure by the State or County professional association; and	Full-2014			
N. Most recent information available from the National Practitioner Data Bank.	Full-2014			
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;	Full-2014			
B. Lack of present illegal drug use;	Full-2014			
C. History of loss of license and felony convictions;	Full-2014			
D. History of loss or limitation of privileges or disciplinary activity;	Full-2014			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full-2014			
F. Applicant attests to correctness and completeness of the application	Full-2014			

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**
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-2014			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Full-2014			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full-2014			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Full-2014			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Full-2014			
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.	Full-2014			
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing	Full-2014		Includes Recredentialing file review summary results	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
decision, the Contractor has verified information about sanctions or limitations on practitioner from:				
A. A current license to practice;	Full-2014			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full-2014			
C. A valid DEA number, if applicable;	Full-2014			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full-2014			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Full-2014			
F. A current signed attestation statement by the applicant regarding:	Full-2014			
1. The ability to perform the essential functions of the position, with or without accommodation;	Full-2014			
2. The lack of current illegal drug use;	Full-2014			
3. A history of loss, limitation of privileges or any disciplinary action; and	Full-2014			
4. Current malpractice insurance.	Full-2014			
There shall be evidence that before making a recredentialing decision, the Contractor has verified	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
information about sanctions or limitations on practitioner from :				
A. The national practitioner data bank;	Full-2014			
B. Medicare and Medicaid;	Full-2014			
C. State boards of practice, as applicable; and	Full-2014			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full-2014			
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.	Full-2014			
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.	Full-2014			
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Full-2014			

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**
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.	Full-2014			
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.	Full-2014			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Full-2014			
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.	Full-2014			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full-2014			
28.1 Network Providers to be Enrolled				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor	Substantial- LOB1300 Passport Annual Report provides accessibility for PCPs,	Substantial	Credentialing 2.7.1.1 addresses any willing provider statute as described in 907 KAR	**Passport Response:** Passport Health Plan has acted upon IPRO's

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**
shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists, advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech therapists, physical therapists, occupational therapists, private duty nursing agency, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers,	Dental, Specialty providers, Non-Physician Providers, Hospitals, Urgent Care Ctrs., FQHCs, Pharmacy, Family Planning Clinics, Maternity, Vision, and BH. Requirements pertaining to FQHC are addressed in PC 84.0 Behavioral Health Provider contracting and Enrollment. No documentation was provided that addresses that the Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Additionally, the documents submitted do not address all provider types found in this requirement. **Recommendation for PHP** The plan needs to add language to its policies and procedures that addresses the specific provider types denoted in this requirement and the plan also needs to address the willing provider statute detailed in 907 KAR 1:672 and KRS 304.17A-270. **MCO Response:** Passport acknowledges the recommendations.		1:672 and KRS 304.17A-270. PC 83.0, CR 6.01, CR 1.01 address accessibility for a range of provider types. EP 17.0 EPSDT Scope of Services is evidence that the Plan provides access to EPSDT services through the members' PCPs or through the Department of Health. Page 27 of the Pharmacy Benefit Management (PBM) Program Description is evidence that the Plan provides access to pharmacy services through Magellan, the pharmacy benefit subcontractor. None of the documentation mentioned accessibility to the following: o free-standing birthing centers o private duty nursing agency o Certified Peer Support Providers o Certified Parental Support Providers. **Recommendation** It is recommended that Passport add to its policies and procedures the requirements pertaining to accessibility to free-standing birthing centers, private duty nursing agencies, Certified Peer Support Providers and Certified Parental Support Providers.	recommendation by updating Policies PC 83.0, CR 6.01 and CR 8.01 to include Free-standing birthing centers and private duty nursing agency provider types. Passport Health Plan has updated Policy PR13.0 for Access and Availability Standards to include Certified Peer Support Providers and Certified Parental support Providers. We recognize these provider types are expected to be part of a program i.e. ACT. The "program" enrolls and reimburses these types of providers. PC 83.0 Provider Contracting ... CR 6. 01 - Organizational Provid CR 8.01 - Organizational Provid

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**
psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Certified Peer Support Providers, Certified Parental Support Providers, and Licensed Clinical Social Workers. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				PR1310 Access Availability St...
Providers performing laboratory tests are required to be certified under the CLIA. The Department will	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.				
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.	Substantial- This requirement is addressed in CR 6.01 Organizational Provider Credentialing/ Recredentialing Policy and Procedure. The Provider Manual does not address this requirement. **Recommendation for PHP** The plan should include this requirement in its Provider Manual. **MCO Response:** Passport agrees with the recommendation.	Substantial	The requirement related to providers who service high-risk populations is included in the page 22 excerpt of the Provider Manual, which is evidence that the Plan intends to incorporate the required text into the Provider Manual. However, the version of the Provider Manual submitted for review, dated January 2014, did not yet contain the required text. **Recommendation** It is recommended that Passport finalize its Provider Manual to include the requirement language pertaining to providers who service high-risk populations.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating the Provider Manual, Section 2.7.1, to specifically include the selection and retention of providers that service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification will not be discriminated against. Please see the attached Provider Manual, page 8, Section 2.7.1. Provider Manual Section 2-Administrat

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.	Full-2014			
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.	Non-Compliance- No documentation was provided that stated that the plan must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor. **Recommendation for PHP** The plan needs to add this contractual language to its policies and procedures. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by developing Policy PC 85.0, Electronic Health Record Incentive Funds. PC 85 - Electronic Health Record Incentiv	Full	This requirement is addressed in PC 58 Electronic Health Record Incentive.	
28.2 Out-of-Network Providers				

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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 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-2014			
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The	Non-Compliance-Documentation provided does not address the requirement that the contractor may enroll providers in their network who are not participating in the KY Medicaid Program as long as the providers meet the credentialing standards described in the Credentialing and Re-Credentialing of the contract with the state and are eligible to enroll with the KY Medicaid Program. Additionally, no documentation was provided that detailed that a provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the	Full	This requirement is addressed in the Practitioner Credentialing and Practitioner Recredentialing Policy.	

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor shall 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.	Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. **Recommendation for PHP** The plan should add this contractual language to its policies and procedures as well as to the Provider Manual. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendations by updating the language in policy CR 1.01, Practitioner Credentialing Policy and Procedures and CR 4.01, Practitioner Recredentialing Policy and Procedure to include the recommended information. These Policies are pending internal Passport approval. IPRO Comment: Passport Health Plan should submit the revised P/Ps to DMS once approved.			
28.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to	Full-2014			

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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**
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.				
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-2014			
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,	Full-2014			

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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**
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.				
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	The Coordination of Care due to PCP Termination both Voluntary and Involuntary documentation describes the Plan's procedures in the event of an involuntary termination. It describes how the PR Specialist starts the process of termination within 1 business day of termination notice receipt.	
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-2014			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within 15 days of the action taken if it is a PCP and within 30 days for any other Provider.	Not Reviewed	Substantial	The Coordination of Care due to PCP Termination both Voluntary and Involuntary documentation partially meets this requirement as the Plan notifies affected members of their PCPs termination 30 days prior to the effective date. However, this policy only applies to PCPs and does not include specialists. **Recommendation** Onsite, Passport submitted the Coordination	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating and approving Policy PR 134.0 - Coordination of Care due to Provider Termination both Voluntary and Involuntary to include PCP and Specialist. Please also see the Provider Manual, Section 2.3.1., page 4, previously attached above.

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**
			of Care due to Specialist Provider Termination Policy, which was created on 3/17/15. This Policy addresses terminations for any other provider that is not a PCP. It is recommended that Passport finalize this document and that compliance for this standard by reevaluated during the next audit cycle.	PR 134 0 - Coordination of Care
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-2014			
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	The Coordination of Care due to PCP Termination both Voluntary and Involuntary Policy meets this requirement.	
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Not Reviewed	Full	The PCP contracts and other provider contracts meet this requirement fully.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within 15 days of providing notice or (ii) 30 days prior to the effective date of the termination.	Not Reviewed	Full	The Coordination of Care due to PCP Termination both Voluntary and Involuntary Policy meets this requirement.	

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**	**3**	**0**	**0**
Total Points	18	6	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	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility

Final Findings

Shading of Columns for Review Determination, Comments and Health Plan's and DMS' 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

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: Passport Health Plan

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.	Full-2014			
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's				

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**
policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Full-2014			
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;	Full-2014			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full-2014			
D. Discussing Advance Medical Directives with all Members as appropriate;	Full-2014			
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;	Full-2014			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full-2014			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full-2014			
Maintaining formalized relationships with other PCPs to refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;	Full-2014			
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and	Full-2014			
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.	Full-2014			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Full-2014			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Full-2014			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Full-2014			

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**
(4) Returning after-hours calls outside of thirty (30) minutes.	Full-2014			
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.	Substantial- PCP Contract State Wide addresses the requirement for Covered services in terms of timeliness, amount, duration, and scope. Requirement met per PCP Agreement sections: 3.8 Provider shall not discriminate based upon source of payment. 3.11 Appropriate and adequate medical care. 3.5 Basic health services with same standard of care as community providers. However, language does not specify that "no incentive is provided…to providers for the withholding from members of medically necessary services." **Recommendation for PHP** Add language regarding "no incentive… to withhold services" to relevant policy/procedure document. **MCO Response:** Passport agrees with the recommendation.	Full	This requirement is addressed in the PCP Contract at Sections 3.8, 3.11, 3.5 and 4.1.	
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provide covered services consistent with the requirements specified in this section.				
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:	Full-2014			
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
B. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four (24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals.	Full-2014			
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department in no fewer number than 25% of the Specialists enrolled in	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.				
D. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Full-2014			
E. Access to hospital care shall not exceed 30 miles or 30 minutes of a Member's residence in an urban area, or 60 minutes of a Member's residence in a non-urban area, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed 60 miles or 60 minutes.	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 3 weeks for regular appointments and 48 hours for urgent care.	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
G. Access for general vision, laboratory and radiology services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 30 days for regular appointments and 48 hours for Urgent Care.	Full-2014		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	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
than 50 miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.			Quarterly Desk Audit results)	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;	Full-2014			
B. FQHCs and rural health clinics;	Full-2014			
C. The Kentucky Commission for Children with Special Health Care Needs; and	Full-2014			
D. Community Mental Health Centers	Full-2014			
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.	Substantial- Policy CR 21.0 Non-Participating Provider Claims Set-Up addresses this requirement. Although this policy does not specifically document submission to the Department, Plan described relevant collaboration with State. **Recommendation for PHP** The policy should be revised to include submission to the Department. **MCO Response:** Passport agrees with the recommendation.	Full	This requirement is addressed in full in the Non Participating Provider Claims Set-Up Policy.	
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the				

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
B. Provide reimbursement at rates commensurate with those provided under Medicare.	Full-2014			
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Full-2014			
The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.	Full-2014			
28.8 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix G that demonstrates that the Contractor	Full-2014		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.			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-2014		Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results)	
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.	Full-2014			
30.1 Medicaid Covered Services				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.	Full-2014			
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Full-2014			
After the Execution Date and the adjustment for ACA compliance, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Full-2014			
Any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Full-2014			
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.	Full-2014			
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.	Full-2014			
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).	Full-2014			
32.4 Out-of-Network Emergency Care				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in compliance with 42 CFR 438.114.	Full-2014			
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.	Non-Compliance- At on-site interview, the Plan stated that payment would never exceed 90% of the DMS fee schedule, and that this limit was stated in policy CR 21.0 Non-Participating Provider Claims Set-Up; however, the policy document provided did not address this limit. **Recommendation for PHP** Policy should be revised to include reference to the Medicaid fee-for-service rate. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by adding language to include reference to the Medicaid fee-for-service rate. CR 21.0, Non-Participating Provider Claims Set-Up, see page 2, 6 B. CR 21 0 - Non Participating Provider	Full	This requirement has been addressed in full in the Non Participating Provider Claims Set-Up Policy.	
30.2 Direct Access Services				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.	Full-2014			
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Full-2014			
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Full-2014			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full-2014			
D. Maternity care for Members under 18 years of age;	Full-2014			
E. Immunizations to Members under 21 years of age;	Full-2014			

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**
F. Sexually transmitted disease screening, evaluation and treatment;	Full-2014			
G. Tuberculosis screening, evaluation and treatment;	Full-2014			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Full-2014			
I. Chiropractic services; and	Full-2014			
J. Women's health specialists.	Full-2014			
32.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.	Full-2014			
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.	Substantial- Provider contract, 6.1, includes a general provision regarding confidentiality of medical records, but it is not specific to family planning services provided to members <18 years of age. Family Planning contract with AmeriHealth also does not address this requirement. **Recommendation for PHP**	Full	This requirement is addressed in full in the Provider Manual at Section 14.0.	

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**
	Contracts should be revised to specifically address family planning services. **MCO Response:** Passport agrees with the recommendation.			
All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.	New Requirement	Full	This requirement is addressed in Section 3.26 of the Urgent Care Services part of the Provider Agreement.	

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

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	0	0	0
Total Points	15	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' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

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

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

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

Final Findings

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

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

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

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-2014			
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Full-2014			
The description shall include the scope of the program;	Full-2014			
the processes and information sources used to determine service coverage;	Full-2014			
clinical necessity, appropriateness and effectiveness;	Full-2014			
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Minimal- The UM Program Description referred to policies and procedures regarding Care Coordination and Discharge Criteria. Cultural Competence of Care Delivery is only addressed by a statement of compliance with Title VI of the Civil Rights Act of 1964 regarding translation of materials. Site of Services and Triage Decisions were not found within the	Full	This requirement is addressed in policy UM 35.00 Review Process; definitions, Sites of Service, Level of Care, Triage and Discharge Planning (also addressed in UM 9.01 Discharge Planning); Utilization Management and Program Description; Cultural Competency. Cultural Competency, Desk Top Procedures addresses cultural competency responsibilities.	

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**
	documentation. Policy language regarding Levels of Care is mentioned only in conjunction with transitioning a Member to an alternate level of care. No clear definition or procedure given specifically for Levels of Care. **Recommendation for PHP** The plan needs to fully develop in its policies and procedures how it handles care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation and has revised the policies listed below to reflect how it handles Care Coordination, Discharge Criteria, Site of Service, Levels of Care, Triage Decisions and Cultural Competence: Care Coordination - UM 35.00 Review Process Policy and Procedure revised: See # 1A Care Coordination Also in UM / Clinical Programs Description 1G Page 21			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	UM 35 00 Review Process.docx 2014 Utilization Mng and Clinical Programs Discharge Criteria - Had existing Policy and Procedure UM 9.01 Discharge Planning Also added to UM 35.00 Review Process 1E DC planning Also in UM / Clinical Programs Description 1F Page 21 UM 9.01 Discharge Planning.docx Sites of Service - UM 35.00 Review Process Policy and Procedure revised: See # 1B labeled Sites of Service Also added to UM / Clinical Programs Description 1D Page 19			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Levels of Care - UM 35.00 Review Process Policy and Procedure revised: See # 1C labeled 1C Level of Care Also added to UM / Clinical Programs Description 1E Page 19 Triage Decisions - UM 35.00 Review Process Policy and Procedure revised: See 1D Triage Also added to UM / Clinical Programs Description 1C Page 19 Cultural competence of care delivery New Desk Top Procedure created – Cultural Competence Also added to UM / Clinical Programs Description 1B Page 11 Cultural Compentence.docx			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Full-2014			
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.	Full-2014			

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 QI Committee.	Full-2014			
The Contractor shall adopt Interqual, Milliman or other nationally recognized standards and criteria for Medical Necessity review which shall be approved by the Department.	Full-2014			
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.	Full-2014			
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-2014			
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Full-2014		Includes UM file review results	
The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.	Full-2014		Includes UM file review results	
The reason for the denial shall be cited.	Full-2014		Includes UM file review results	

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**
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.	Full-2014			
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.	Full-2014			
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Non-Compliance- Documentation was not provided that shows that the plan submits its request to change any prior authorization requirement to DMS for review. **Recommendation for PHP** A policy/procedure should be developed addressing the requirement that the plan submit all requests to change any prior authorization to the Department for review and keep a copy of the documentation for its files. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendations by developing a New Desk Top Procedure: Utilization Management Program Modifications Also added to UM / Clinical Programs Description 1H Page 24	Full	This requirement is addressed in policy Utilization Management Program Modifications and 2014 Utilization Management and Clinical Programs Description.	

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**
	Utilization Management Program 2014 Utilization Mng and Clinical Programs			
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.	Full-2014			
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within 3 working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.	Full-2014			
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Full-2014			

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.	Substantial- The PHP UM Program Description discusses Outpatient Prior Authorization. No documentation was provided that mentions how prior authorization data will be incorporated into PHP's overall Quality Improvement Plan. Prior authorization data is addressed in the QI Work Plan and annual QI Program Evaluation. **Recommendation for PHP** The plan needs to address in policies and procedures how prior authorization data will be incorporated into the overall QI Plan. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by adding language to UM 1.01 Utilization Management Program – Letter I Also added to UM / Clinical Programs Description 1I page 24 UM 1.01 Utilization Management Program	Full	This requirement is addressed in policy UM 1.01 UM Program and Utilization Management Programs.	

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**
	2014 Utilization Mng and Clinical Programs			
F. The Contractor shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.	New Requirement	Not Applicable	This requirement was not addressed. During the onsite, the Plan submitted policy UM 43.0 Phase III and Phase IV Clinical Trials, which was created and approved on 3/17/15, which is outside of the review period. Page 3 states that Phase III and IV clinical trials are a covered benefit, and the Medical Director is to review the request and determine Medical Necessity. **Final Review Determination** The review determination is changed to Not Applicable. DMS has indicated that this requirement is not applicable.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by developing a specific policy related to clinical trials, UM 43.0, to ensure compliance. Utilization Management utilizes policy UM 35.0 that states cases are referred to the Medical Director that do not meet criteria and UM 4.01 Medical Director review which states the Nurse and Medical Director applies criteria including Kentucky State Medicaid Guidelines which would have covered clinical trial review. UM Policy 43.0 - Phase III and Phase I **DMS Response** Passport should keep policy 35.00 in place at this time.
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	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provide incentives for the individual or entity to 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-2014			
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Full-2014			
The UM program will be evaluated by DMS on an annual basis.	Substantial- The 2012 UM Program Evaluation states that "an evaluation of the Utilization Management Program is conducted annually". It does not reference submission to DMS. **Recommendation for PHP** The plan should add language into its policies and procedures that the UM Program Evaluation is submitted to DMS annually. **MCO Response:** Passport Health	Full	Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results) This requirement is addressed in UM 1.01 UM Program and Quarterly Desk Audit Results, MCO Report #59 Prior Authorizations.	

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**
	Plan has acted upon IPRO's recommendation by adding language to UM 1.01 Utilization Management Program – Letter H UM 1.01 Utilization Management Program			
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-2014			
(a) The action the Contractor has taken or intends to take;	Full-2014		Includes UM file review results	
(b) The reasons for the action in clear, non-technical language that is understandable by a layperson;	Full-2014		Includes UM file review results	
(c) The federal or state regulation supporting the action, if applicable;	New Requirement	Full	Includes UM file review results UM file review was deemed this year and not performed. This requirement is addressed in 2014	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Utilization Management and Clinical Programs Description and XIV State Fair Hearing.	
(d) The Member's right to appeal;	Full-2014		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-2014		Includes UM file review results	
(g) Circumstances under which expedited resolution is available and how to request it; and	Full-2014		Includes UM file review results	
(h) The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Full-2014		Includes UM file review results	
20.8 Timeframe for Notice of Action Related to Medical Necessity or Coverage Denials				
The Contractor must give notice of an Action related to medical necessity or coverage denials at least: A. Ten (10) days before the date of Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.	Full-2014			
B. The Contractor must give notice by the date of the Action for the following:				

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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**
1. In the death of a Member;	Full-2014			
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-2014			
3. The Member's admission to an institution where he is ineligible for further services;	Full-2014			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Full-2014			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Full-2014			
6. The Member's physician prescribes the change in the level of medical care;	Full-2014			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Full-2014			
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-2014			
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.	Full-2014			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.	Full-2014		Includes UM file review results	
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-2014		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-2014			
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for	Full-2014			

Final Findings

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

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	5	0	0	0
Total Points	15	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' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

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

Documents

Policies/procedures for:

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

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

Reports

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

File Review

Sample of UM files selected by EQRO

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

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
36. Program Integrity				
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 six (6) months to provide a new or revised program. This plan shall include, at a minimum:	Full-2014			
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;	Full-2014			
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;	Full-2014			
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;	Full-2014			
D. Effective lines of communication between the compliance officer and the organization's employees;	Full-2014			
E. Enforcement of standards through disciplinary	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
guidelines;				
F. Provision for internal monitoring and auditing of the member and provider;	Full-2014			
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;	Full-2014			
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;	Full-2014			
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full-2014			
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;	Full-2014			
K. Contractor shall provide procedures for appeal process;	Full-2014			
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2014			
M. Contractor shall create a process for card sharing cases;	Full-2014			
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the	Full-2014		Includes review of MCO Report #75 SUR Algorithms	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;				
O. Contractor shall follow cases from the time they are opened until they are closed; and	Full-2014			
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2014			
The plan shall be made available to the Department for review and approval.	Full-2014			
9.1 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
37.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, 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 (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;	Full-2014		Includes review of individual disclosures	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Full-2014		Includes review of individual disclosures	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;	Full-2014		Includes review of individual disclosures	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;	Full-2014		Includes review of individual disclosures	
E. The identity of any person who has an ownership 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	
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Full-2014		Includes review of individual disclosures	
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 that shall with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and ongoing basis;	Full-2014			
B. Written policies, procedures, and standards of conduct that demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards;	Full-2014			
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with Federal and State requirements;	Full-2014			
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full-2014			
E. The unit prioritizes work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:	Full-2014			
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Full-2014			
(2) High dollar amount of potential overpayment; or	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Full-2014			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full-2014			
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2014			
FUNCTION: The Contractor and/or Contractor's PIU shall:	Full-2014			
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Full-2014			
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Full-2014			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full-2014			
D. Initiate appropriate administrative actions to collect overpayments;	Full-2014			
E. Refer potential Fraud, Waste and Abuse cases to	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the 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-2014			
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Full-2014			
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Full-2014			
I. Provide for internal monitoring and auditing of Contractor and its subcontractors; and supply the Department with quarterly reports or as-requested basis on its activity or ad hocs as necessary;	Full-2014			
J. Being subject to on-site review and fully comply with requests from the Department to supply documentation and records;	Full-2014			
K. Create an accounts receivable process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the Department;	Full-2014		Includes review of MCO Report #71 Provider Outstanding Account Receivables	
L. Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after 180 days;	New Requirement	Full	This requirement is addressed in the Program Integrity Accounts Receivable Procedure.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
M. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;	Full-2014			
N. Conduct regularly 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-2014			
O. Conduct onsite and desk audits of Providers and report the results, including identified overpayments and recommendations to the Department;	Full-2014			
P. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Full-2014			
Q. Designate a contact person to work with investigators and attorneys from the Department and OIG;	Full-2014			
R. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Full-2014			
S. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2014		Includes review of MCO Report #73 Explanation of Member Benefits (EOMB)	
T. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly	Full-2014		Includes review of MCO Report #75 SUR Algorithms	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;				
U. Collect administratively from Members for overpayments that were declined prosecution, for Medicaid Program Violations (MPV);	Full-2014			
V. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review and approval;	Full-2014			
W. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Full-2014			
X. Recover overpayments from Providers and identify Providers for pre-payment review as a result of the Provider's activities;	Full-2014			
Y. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department; and	Full-2014			
Z. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or 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-2014			
PATIENT ABUSE:	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 and with copy to the Department and OIG.				
COMPLAINT SYSTEM: The Contractor's PIU shall operate a system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:				
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;	Full-2014			
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Full-2014			
C. If the preliminary inquiry results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU shall take whatever remedial actions may be necessary, up to and including, administrative recovery of identified overpayments;	Full-2014			
D. If the preliminary inquiry results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the OIG, with a copy to the Department;	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. The 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-2014			
F. If in the process of conducting a preliminary review, the PIU suspects a violation of either criminal Medicaid Fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the OIG with a copy to the Department of their findings and proceed only in accordance with instructions received from the OIG;	Full-2014			
G. If the OIG determines that it will keep a case referred by the PIU, the OIG will conduct a preliminary investigation, gather evidence, write a report and forward information to the Department, the PIU, or if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate actions;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, the 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	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;				
K. Upon completion of the PIU's preliminary review, the PIU shall provide the Department and the OIG a copy of their investigative report, which shall contain the following elements:	Full-2014			
(1) Name and address of subject,	Full-2014		Includes Program Integrity file review results	
(2) Medicaid identification number,	Full-2014		Includes Program Integrity file review results	
(3) Source of complaint,	Full-2014		Includes Program Integrity file review results	
(4) State the complaint/allegation,	Full-2014		Includes Program Integrity file review results	
(5) Date assigned to the investigator,	Full-2014		Includes Program Integrity file review results	
(6) Name of investigator,	Full-2014		Includes Program Integrity file review results	
(7) Date of completion,	Full-2014		Includes Program Integrity file review results	
(8) Methodology used during investigation,	Full-2014		Includes Program Integrity file review results	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,	Full-2014		Includes Program Integrity file review results	
(10) Attach all exhibits or supporting documentation,	Full-2014		Includes Program Integrity file review results	
(11) Include recommendations as considered necessary, for administrative action or policy revision,	Full-2014		Includes Program Integrity file review results	
(12) Identify overpayment, if any, and include recommendation concerning collection,	Full-2014		Includes Program Integrity file review results	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(13) Any other elements identified by CMS for fraud referral.	New Requirement	Full	This requirement is addressed in the Program Integrity Plan Reporting.	
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;	Full-2014		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report	
M. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and	Full-2014			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full-2014			
REPORTING: The Contractor's PIU shall report on a quarterly basis in a narrative report format all activities and processes for each investigative case (from opening to closure) to the Department. If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.	Full-2014		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-2014		Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(1) PIU Case number;	Full-2014		Includes review of MCO Report #76 and Report #77	
(2) OIG Case number if one has been assigned;	NA- This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided. DMS template reports for Reports 76 and 77 do not include this requirement. **Recommendation for DMS** DMS should consider including OIG case number in the template reports for Reports 76 and 77.		Includes review of MCO Report #76 and Report #77	
(3) Provider/Member name;	Full-2014		Includes review of MCO Report #76 and Report #77	
(4) Provider/Member number;	Full-2014		Includes review of MCO Report #76 and Report #77	
(5) Date complaint received by Contractor;	Full-2014		Includes review of MCO Report #76 and Report #77	
(6) Source of complaint, unless the complainant prefers to remain anonymous;	Full-2014		Includes review of MCO Report #76 and Report #77	
(7) Date opened and name of PIU investigator assigned;	Full-2014		Includes review of MCO Report #76 and Report #77	
(8) Summary of complaint;	Full-2014		Includes review of MCO Report #76 and Report #77	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);	NA- This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.		Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Quarterly Reports 72, 76 and 77 were provided. DMS template reports for Reports 76 and 77 do not include this requirement. **Recommendation for DMS** DMS should consider including this requirement in Reports 76 and 77.			
(10) PIU action taken and date (only provide the most current update);	Full-2014		Includes review of MCO Report #76 and Report #77	
(11) Amount of overpayment (if any) and time span;	Full-2014		Includes review of MCO Report #76 and Report #77	
(12) Administrative actions taken to resolve findings of completed cases;	Full-2014		Includes review of MCO Report #76 and Report #77	
(13) The overpayment required to be repaid and overpayment collected to date;	Full-2014		Includes review of MCO Report #76 and Report #77	
(14) Describe sanctions/withholds applied to Providers/Members, if any;	Full-2014		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, the date and decision of the final order;	Full-2014		Includes review of MCO Report #76 and Report #77	
(16) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented revision and date of implementation; and	Full-2014		Includes review of MCO Report #76 and Report #77	
(17) Make MIS system edit and audit recommendations as applicable.	Full-2014		Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Full-2014			
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;	Full-2014			
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;	Full-2014			
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or the OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;	Full-2014			
E. Produce records in electronic format for review and manipulation by the Department and the OIG;	Full-2014			
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;	Full-2014			
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	Full-2014			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
responsibilities specified in this Contract;				
H. Fully cooperate with the Department, OIG, the United States Attorney's Office and other law enforcement agencies in the investigation of Fraud or Abuse cases; and	Full-2014			

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Program Integrity

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

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

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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-2014		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-2014			
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034, and who are supported by adequately equipped offices to perform EPSDT services.	Full-2014			
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.	Full-2014			
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during	Full-2014		Includes file review results for EPSDT UM files and EPSDT Appeal files	

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 year.				

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**
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.	Substantial- EPSDT screening components are described in the Provider Manual, the EPSDT Orientation Packet, EPSDT Program Description, P/P EP 17.0, and Clinical Practice Guidelines screenshot of the plan's provider website. Members' receipt of screening is tracked by the plan as evidenced by the provided EPSDT Call Center application screenshot, and referrals are tracked as	Substantial	As noted in the prior review, the 2014 EPSDT Program Description and Policy and Procedure EP 17.0 EPSDT Scope of Services indicate that Passport continues to conduct member outreach and EPSDT home visits, provider education, provides resources, issues lists of members due/overdue for screens, offers an EPSDT Provider Recognition program, tracks EPSDT services, and conducts audits of EPSDT medical records. The recommendation from the prior review,	**DMS Response** The link to the managed care organization (MCO) website for the periodicity schedule needs to be fixed in a timely manner. **Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by fixing the link on the website in both places under the Provider tab under Medical Management, Clinical Practice Guidelines and under the Provider

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	evidenced by NaviNet. The Provider Manual states that the plan will no longer use the state periodicity schedule as a guide to screening and will now use the American Academy of Pediatrics Guidelines for screening interval recommendations. These guidelines are available in the documents listed above. It was discussed with onsite staff that AAP guidelines in provided documents require updating with most recent AAP guidelines. As per the EPSDT Program Description, Provider Manual, and P/P 17.0, providers are sent a monthly report listing members who are due/overdue for recommended screenings, as per the EPSDT Call Center application provided; a screen shot of a care gap report was also submitted. The Care Gap Report lists each member and the screenings due, screening expiration date, previous screens performed, and completion date. Eligible members may opt-out with written notice to the plan as		to include the most recent AAP Guidelines in the Program Description and Policy, was not fully addressed. The 2014 EPSDT Program Description and the Policy and Procedure EP 17.0 EPSDT Scope of Services were both updated with the 2014 version of the AAP/Bright Futures Periodicity Schedule. However, in the Provider Manual, there is a link to the managed care organization (MCO) website for the periodicity schedule. When clicking the link, it leads to an error message from the Passport website. Passport should fix the link. During the prior review, IPRO found that no EPSDT audits had been completed. For the current review, the MCO submitted the results for audits as of October 2014. The report indicates that 62 reviews have been scheduled and 42 completed. The report is limited to Region 3. The MCO stated that providers are educated in year one and monitored in year two. For Region 3, education occurred in 2013 and monitoring in 2014. Education for other regions occurred in 2014 and monitoring will occur in 2015. The External Quality Review Organization (EQRO), IPRO, conducted an EPSDT validation study in 2013 and is currently conducting another in 2014 in which Passport is participating.	Manual, EPSDT, Section 8.3. Passport has also verified that the link has been corrected.

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**
	per the Member Handbook and P/P EP 17.0. A sample outreach letter was submitted as evidence of further instruction to the member on the process to withdraw from the EPSDT Outreach Program. The plan's EPSDT Program Description includes random claims audit; onsite staff indicated that no audits had been conducted in the review period. **Recommendation for PHP** The plan should ensure that most recent AAP guidelines, including 2014 AAP periodicity schedule, are included in documents. The plan should continue to validate EPSDT services through claims audits as planned and as described in the Program Description. **MCO Response:** Passport acknowledges the recommendation.		**Recommendation for Passport** The MCO should repair the link in the Provider Manual to allow providers to access the periodicity schedule available on the MCO website. The claims audits for other regions should be completed in 2015 as planned.	
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	Substantial- As per the Provider Manual, the plan monitors PCP actions for compliance with PHP	Substantial	As noted above, the EPSDT program components continued in 2014.	**Passport Response:** Passport Health Plan has acted upon IPRO's

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**
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.	and DMS policies. This includes maintaining an up to date medical record for preventive health and well child care visits, the provision of timely reminders to eligible members according to the AAP/Bright Futures Periodicity Schedule and CDC recommended Immunization Schedule. The EPSDT Orientation Packet encourages providers to use NaviNet to obtain patient histories and check for screenings that are due/overdue. NaviNet also provides additional training materials on scheduling EPSDT services. Providers are required to attempt to reach noncompliant members three times before contacting PHP EPSDT Outreach team. The Provider Orientation Kit outlines the provider's responsibility to complete age-appropriate EPSDT services within 30 days of plan enrollment unless the member is up to date with all screenings and vaccinations. The Kit also describes the Provider Recognition Program		The recommendation from the prior review was not fully addressed During the prior review, IPRO found that no EPSDT audits had been completed. For the current review, the MCO submitted the results for audits as of October 2014. The report indicates that 62 reviews have been scheduled and 42 completed. The report is limited to Region 3. The MCO stated that providers are educated in year one and monitored in year two. For Region 3, education occurred in 2013 and monitoring in 2014. Education for other regions occurred in 2014 and monitoring will occur in 2015. **Recommendation for Passport** The claims audits for other regions should be completed in 2015 as planned.	recommendation by currently finishing the final offices for the 2014 review. The 2015 EPSDT Audit sample will be pulled in September of this year with auditing beginning shortly thereafter.

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**
	which awards financial incentives for performance on EPSDT measures. As noted above, no audits were conducted in the review period. **Recommendation for PHP** The plan should continue to validate EPSDT services through claims audits as planned and as described in the Program Description. **MCO Response:** Passport agrees with the recommendation.			
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers shall provide treatment if the service is not available with the Contractor's Network.	Full-2014			
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J.	Full-2014			
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	Full-2014			

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Special Services when needed.				
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.	Full-2014			
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.	Substantial- P/P EP 17.0 indicates reports are generated by the EPSDT Department based on claims data to track the number of comprehensive screens reported by age, on time screens, routine evaluation of Hematocrit/Hemoglobin levels, referrals made during the EPSDT screening visit for children up to age 21, immunization history, and automated outreach. Outreach is also described in the 2013 EPSDT Program Description. The plan provided a screen shot of the PHP EPSDT Call Center application that tracks screens due for each member, last screen conducted and outreach, with results of the outreach call,	Minimal	The MCO submitted a screen print from the EPSDT Call Center Application. During the onsite interview, the MCO reported that the business requirements for linking the screening and referral databases had been developed. Possible vendors for implementing the requirements have been interviewed and the MCO is currently deciding whether to perform the work internally or to outsource to a vendor. Policy and Procedure EP 17.0 indicates the following: "The PCP is responsible for coordinating all of the member's health care. If member is referred for corrective treatment, as a result of an EPSDT screen, the PCP will complete and issue a referral to the specialist. The referral information must be documented in member's medical record. In addition, PCP's are required to denote whether a referral to a specialist was issued as a result	**DMS Response** Since the IPRO recommendation from the prior compliance review was not fully addressed, a CAP will be required. **Passport Response:** Passport Health Plan has acted upon IPRO's prior recommendation to develop and implement a tool to identify and follow up on referrals made as a result of an EPSDT visit. Additionally, Passport is diligently investigating options to improve the entire process of EPSDT to be more member centric and to wrap services around the member.

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**
	including disposition and date and time of appointment. Members that opt-out must refuse in writing; refusals are scanned and maintained as per P/P EP 17.0. The plan provided a screen shot of a report of the tracking system of EPSDT screens due; this includes the date of last screen and date screens are due for each member, as well as the PCP. A screenshot of the electronic referral form from NaviNet was submitted to show how providers complete referrals with diagnosis codes required. A paper referral form was also submitted by the plan. As per onsite staff, required screenings and referrals are documented separately in two different databases. The plan is currently working to link the two databases. The EPSDT Referral Tracking screenshot shows a flow diagram illustrating the plan's process to identify an EPSDT referral and to identify and ensure ESPDT members receive all medically necessary services to be compliant with federal EPSDT		of an age-appropriate EPSDT screen. EPSDT-related referrals (EPSDT Expanded Services) are collected and forwarded to an EXP file on a daily basis. The EPSDT team retrieves the referral report from EXP and provides outreach to ensure members follow-up on recommended specialty services. The EPSDT Department works with the IT, Data, and Compliance departments to generate reports based on information obtained from the EPSDT claims data. The following information can be obtained: Number of comprehensive screens reported by age, On time screens, Routine evaluation of Hematocrit/Hemoglobin levels, Referrals made during the EPSDT screening visit for children up to age 21, Immunization history, Automated outreach." This is scored a minimal because the MCO did not make sufficient progress on the prior year recommendation.	

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**
	program guidelines. P/P EP17.0 indicates the PCP is responsible for coordination of care for referrals and the referral must note the findings based on EPSDT screening. EPSDT-related referrals are collected into an EXP file daily. **Recommendation for PHP** Currently there are two systems for tracking screening and referrals. The plan should continue with efforts to link the screening and referral database to ensure that the needs of each individual member can be easily tracked in one record and receipt of appropriate services ensured. **MCO Response:** Passport agrees and continues to work towards a single database for tracking.			
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.	Full-2014			

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**
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.	Full-2014			
K. Participate in any state or federally required chart audit or quality assurance study.	Full-2014			
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.	Substantial- EPSDT education is provided through the provider website, NaviNet, the provider manual, the EPSDT Orientation Kit, the New Provider Orientation Packet, and face-to face workshops and onsite visits performed by the Provider Network Account Manager. Details on each of these items as they pertain to relaying information and updates to providers are described in previous items above. The provider newsletter is used to send providers updates to policy changes as per the sample newsletter dated 3/27/13. P/P EP17.0 describes other provider outreach methods including: eNews Alerts, written notice, provider website postings, and provider workshops.	Minimal	Per the 2014 EPSDT Program Description and Policy and Procedure EP 17.0, the provider training program and provider communications for EPSDT continued in 2014 via the website provider page/portal, NaviNet, Provider Manual, EPSDT Orientation Kit, workshops, onsite visits, newsletters, and mailed gap lists. Discussion of training for specific provider types was not seen. The prior recommendations were not fully addressed. The Policies and Procedures do not address provider types such as nurse practitioners, RNs and PAs. Passport submitted documentation of provider training, including content for EPSDT as well as sign-in sheets. The signatures reveal that both physicians and non-physicians attended; however, there are no attendees with credentials that denote Nurse Practitioners (NPs), Registered Nurses (RNs), and Physician Assistants (PAs).	**DMS Response** Since the IPRO recommendation from the prior compliance review was not fully addressed, a CAP will be required. **Passport Response:** Passport Health Plan has acted upon IPRO's prior recommendation by updating the sign in sheet to reflect provider name, provider, ID, and provider type to capture and track all provider types and discipline that receive education/information regarding EPSDT. This tool is utilized during all EPSDT education and audit visits by the QI department EPSDT_Provider_... EP 17.0 EPSDT Scope of Service...

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 current AAP periodicity recommendations for screening (2014), particularly developmental screening, were discussed with onsite staff, including the need to update documents such as the Provider Manual with current recommendations. As per onsite staff, updates are currently under consideration in committees. Rosters of attendance of providers at training workshops were provided. In regards to separate training concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services, no evidence was submitted. Onsite staff indicated that EPSDT services could be provided at local health departments as well as by PCPs; evidence of general training was provided but training specific for non-physician staff was not provided. **Recommendation for PHP**		During the onsite review, the MCO provided proposed updates to Policy and Procedure EP 17.0 addressing outreach, education and support for PCPs and/or designees including, but not limited to, advanced practice registered nurses (APRNs), medical assistants and supporting office staff. A revised sign-in sheet for provider workshops includes an entry for the attendee's title. This is scored a minimal because the MCO did not fully address the prior year recommendation.	For EPSDT education, Passport will utilize a sign in sheet that captures the provider name, provider type, and credentials going forward.

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 plan should ensure that training specific to procedures for non-physicians who may conduct EPSDT services is available. **MCO Response:** Passport acknowledges the recommendation.			
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-2014			
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Full-2014			
22.1 Required Functions				
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.	Full-2014			
37.9 EPSDT Reports				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.	Full-2014		Includes review of MCO Report #93 EPSDT CMS-416	

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MCO: Passport Health Plan

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	0	2	2	0
Total Points	0	4	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average			1.5	

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

Reviewer Decision:

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

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

Final Findings

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

Documents

Policies/procedures for:

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

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

File Review

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

Reports

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

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MCO: Passport Health Plan

Final Findings

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

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.	Full-2014			
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms	Full-2014		Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results)	

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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.	Substantial- P/P CC 4.06 Care Coordination Processes / Scope of Services – provides the guidelines for the Care Management process. Also referenced in the 2013 Complex Case Management Program Description. Although the policy does not make any mention of State approval or the requirement of the Contractor to seek State approval for any changes to the policy, QMMC minutes do document evaluation of member experience of care with CM and changes to CM program description, and Plan staff stated that once approved internally, QMMC minutes are shared with DMS. **Recommendation for PHP** Policy should be revised to include submission of guidelines to the Department. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by sending changes for approval to the Department for Medicaid Services prior to the implementation of such changes to the Complex Care Coordination Program Descriptions and P/P CC.4.06 Care Coordination Processes/Scope of Services policy. Passport Health Plan has added the following language to P/P CC.4.06 Care Coordination	Full	Addressed in Policy and Procedure CC 4.06 Care Coordination Processes/Scope of Services.	

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	Processes/Scope of Services, Policy Statement "Any changes to the Care Coordination Program will be submitted to the Department for Medicaid Services for review and approval prior to implementation of such changes". CC 4 06 Care Coordination Processe			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Full-2014			
34.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Full-2014			
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Full-2014			
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special	Full-2014			

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full-2014		Includes review results for Care Coordination and Complex Case Management files	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Substantial- P/P C7CM MD-1.2-PR-005 Case Management Program Description Process (Case Management Nursing Care Plans) details the care planning process and how care plans are developed. <u>Care Coordination File Review</u> Of the 10 files reviewed for care coordination, 10/10 included documentation of a Care Plan and Behavioral Health-Physical Health (BH-PH) coordination. <u>Complex Case Management File Review</u> Of the 10 complex case management files reviewed, 10/10 included documentation of a care plan; and 9/10 included documentation of care coordination for BH-PH services.	Full	Includes review results for Care Coordination and Complex Case Management files. Addressed in Policy and Procedure CC 13.01 Care Coordination Case Audits which discusses coordination of behavioral health (BH) and physical health (PH) coordination. <u>Care Coordination File Review Results</u> Deemed for 2015. <u>Complex Case Management File</u>	

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for PHP Coordination of BH/PH services should be evident in case management files. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by adding Mental Health Status/Interventions to the Case Management ongoing contact note to ensure addressing behavioral health along with the physical health is accomplished during each contact. Passport Health Plan continues to audit their Care Coordination documentation in order to ensure compliance with care planning and documentation of care coordination for behavioral and physical health. Audits will occur on a random sample of 5 charts per case manager, per month with a performance expectation of 100%. If there are omissions in documentation, one on one remediation will occur with the individual case manager. Auditing will occur for a minimum of three months. If performance expectation of 100% is met at the end of month 3, these elements will be added to the ongoing existing audit per Care Coordination Policy 13.01 Care Coordination Case Audits. CC_13 01 for IPRO w std.docx Ongoing CM Contact.docx		Review Results 10 of 10 files were compliant.	

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Full-2014			
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.	Full-2014			
35.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.	Full-2014			

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.	Full-2014			
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.	Full-2014			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption 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-2014		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-2014			
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-2014			

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	Full-2014			
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.	Full-2014			
35.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.	Minimal- Addressed in P/P FC 10.1 Guardianship Case Management Process. DCBS Service Plan File Review Documentation of ongoing care coordination was not included in the 20 files provided for onsite file review; however, 14 of the 20 files included dual-signed service plans. 19 of 20 showed evidence of use of the service plan to identify whether or not there was a need for case management. None of the cases required referral for case management. DCBS Claims File Review Of 10 files reviewed, 9/10 included documentation of a well visit; 10 of 10 included evidence of EPSDT services or outreach for EPSDT; 10/10 included documentation of care coordination among different service providers.	Substantial	Includes review results for DCBS Service Plans and DCBS Claims/Case Management files. Addressed in Policy and Procedure 10.1 Guardianship Case Management Process-Language which now states that care coordination will be ongoing, not on an "as needed basis." Upon discussion with DMS, review of Service Plans is not applicable. DCBS Service Plan File Review Results 10 of 10 files were compliant for all requirements with the exception	**DMS Response** If this requirement receives a substantial for the 2016 Annual Compliance Review for same reason, it may require a CAP. **Passport Response:** Passport Health Plan has acted upon IPRO's recommendation, effective May 2015, the Foster Care/Adoption/Guardianship Liaison and Manager Out of Home Placements are using Jiva to document case management/care coordination notes. Additionally, they are scheduling dates for future contacts with DCBS or DAIL to discuss any ongoing needs the

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	At the onsite interview, the plan stated that service plans are often not provided from the State; however, service plans were included for most of the sample reviewed. The plan discussed a new State initiative to send the existing form to a PHP DCBS manager. In the past, cases were primarily identified by a DCBS liaison, e.g., medically fragile children were referred to CM. The monthly meeting with the DCBS liaison occurs depending upon whether or not the service plan is turned in. Monthly reports of Foster Care Cases were provided for review. **Recommendation for PHP** DCBS files should include documentation of ongoing care coordination. PHP should continue to work with the State to obtain service plans for all DCBS members. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by working with DCBS since February 2014 to streamline processes related to service plans. After several months of implementation of a new process, we are now receiving more service plans from DCBS. We believe this will continue to improve. DCBS is now notifying us when a foster care member has been assigned to Passport. We have recently		that none of the files contained sufficient evidence of ongoing care coordination. DCBS Claims/Case Management File Review Results Deemed for 2015. Monthly reports of Foster Care Cases were provided for review. During the onsite interviews, the Plan disclosed that DCBS cases are currently tracked using an Excel spreadsheet. The current process does not allow for accurate tracking and reporting. It was recommended that the Plan develop a database that would allow the Plan to capture the information from the service plans and needs assessment, allow for referral/flagging to other departments if necessary, and custom reporting for better tracking/follow-up of these members. The database would be more effective if it was linked/integrated with the Jiva system that is currently being used in Case Management for easy transfer of information.	member may have. For DCBS members, they will be requesting foster parent contact information from the DCBS worker (when it's not already available) at the time of the scheduled contact so that foster parents can be contacted as well. Claims monitoring will also be part of the scheduled reviews.

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	created a database in which to track these identified foster care members. Please see samples below. The database includes spaces to track the date of the current service plan and the date for one annual review of that plan. It also has space to track the date of the child's last EPSDT well visit as well as the next due date for this annual exam. Via the database we can generate reports in order of the next due date, which will better enable us to follow up on missing service plans and reach out when members don't appear to be receiving needed well visits. Except for instances where we identify a need to follow up (such as noted above), ongoing care coordination for DCBS members not enrolled in case management is currently done on an as needed basis. The DCBS MCO Liaisons, DCBS Social Service Workers, and private placement agency staff contact the Foster Care Liaison when needs arise related to access to social, community, medical, and behavioral health services. The Foster Care Liaison maintains a monthly spreadsheet listing the month's contacts, including the member information, the identified need, and the resolution. Sample Foster Care Member Tracking Form Sample Spreadsheet to track monthly Serv IPRO Comment:		**Recommendation for Passport** The MCO should develop a tracking database with more functionality than the current system, as recommended in the onsite interview.	

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	In order to comply with the Contract requirement for ongoing care coordination for DCBS clients who are MCO Members and not enrolled in case/care management, it is not sufficient that Passport Health Plan only provide care coordination on an as needed basis except when a need is identified. DCBS clients who are Passport Health Plan Members must be provided ongoing care coordination services. Passport Health Plan must ensure that the Member's is able to access needed services and resources. Passport Health Plan needs to change the wording in its P/P from "ongoing as needed" to "ongoing." This determination was reviewed by DMS. This can be accomplished via ongoing monitoring of claims and scheduled communications with the DCBS care manager and Member/family.			
35.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.	Full-2014			
35.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in	Substantial- Addressed in P/P FC 13.0 Enrollment	Substantial	Includes review results for DCBS	**Passport Response**

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Process and System Coding for DCBS. Foster Care/Adoption/Guardianship Liaison Job description section 1 states "Serves as primary contact to DCBS; signs each service plan, indicating agreements with each plan, meets monthly with DCBS supervisor, regarding claims, to review service plans, to identify and resolve healthcare issues to meet the needs of children in Out of Home Placement. Works with DCBS staff and Out of Home Placement guardian(s) to develop a care plan when Case Management needs are identified. Works in collaboration with the DCBS to identify DCBS clients for Care Coordination Services." Also referenced in the 2013 Complex Case Management Program Description. Per onsite discussion with plan and as noted in BH 10.0: Identification of DCBS Clients for Behavioral Health Care Coordination of Services Procedure item #2: The PHP Foster Care Case Manager, the PHP Foster Care Liaison, and the DCBS Supervisor jointly review the service form to see if the member is in need of specialized care coordination; if yes, PHP Foster Care Case Manager proceeds with care coordination process. "Trigger List for Care Coordination for Children in Foster Care" includes, but is not limited to, autism, cerebral palsy. <u>DCBS Service Plan File Review</u>		Service Plans files. Addressed in Policy and Procedure BH 10.0 Identification of DCBS Clients for Behavioral Health/Care Coordination Services. Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 10 of 10 files were compliant for all requirements with the exception that none of the files contained sufficient evidence of ongoing care coordination.	Passport Health Plan has acted upon IPRO's recommendation, effective May 2015, the Foster Care/Adoption/Guardianship Liaison and Manager Out of Home Placements are using Jiva to document case management/care coordination notes. Additionally, dates will be scheduled for future contacts with DCBS to discuss any ongoing needs the member may have. They will be requesting foster parent contact information from the DCBS worker (when it's not already available) at the time of the scheduled contact so that foster parents can be contacted as well. Claims monitoring will also be part of the scheduled reviews.

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	14/20 files included dual-signed service plans. At the onsite interview, the plan stated that service plans are often not provided from the State; however, service plans were included for most of the sample reviewed. The plan discussed a new State initiative to send the existing form to a PHP DCBS manager. In the past, cases were primarily identified by a DCBS liaison, e.g., medically fragile children were referred to CM. The monthly meeting with the DCBS liaison occurs depending upon whether or not the service plan is turned in. **Recommendation for PHP** PHP should continue to work with the State to obtain service plans for all DCBS members. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by working with DCBS since February 2014 to streamline processes related to service plans. After several months of implementation of a new process, we are seeing improvement in the number of service plans we receive from DCBS. We believe this will continue to improve. DCBS is also now notifying us when a foster care member has been assigned to Passport. We have created a database in which to track these identified foster care members. Please see samples identified above in Section 35.2. The database includes spaces			

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	to track the date of the current service plan and the date for one annual review of that plan. It also has space to track the date of the child's last EPSDT well visit as well as the next due date for this annual exam. Via the database we can generate reports in order of the next due date, which will better enable us to follow up on missing service plans and reach out when members don't appear to be receiving needed well visits.			
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.	Full-2014		Includes review results for DCBS Service Plans files	
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	Full-2014		Includes review results for DCBS Service Plans files	
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to	Full-2014		Includes review results for DCBS Service Plans files	

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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.				
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-2014			
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.		Non-Compliance	Addressed in Policy and Procedure Care Coordination for Passport Health Plan Members also Receiving First Steps, Early Intervention Services or School-Based IEP Services; however, this Policy and Procedure has not yet been finalized or approved. **Recommendation for Passport** The MCO should approve and	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by approving and implementing the Care Coordination Policy and Procedure CC 30.00, effective April 1, 2015. See attached Policy.

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			implement the Policy and Procedure.	CC 30.00 CC for Passport Health Plan
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Services provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.	Minimal **Recommendation for PHP** The MCO should develop a policy/procedure addressing requirements for coordinating school-based services and early intervention services including prevention of duplicative services and coverage during treatment interruptions. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by updating UM 31.02 Policy Coordination of Care with First Steps for Non-School Aged Children and for Children Receiving School-Based Services and Early Intervention Services to include the following language under number 5, "School based services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based services provided by public health departments are included in Contractor coverage." In addition, a Department of Health/School Based Services Manager has been hired by Passport Health Plan to assist with the coordination of the care provided through all programs as children who are	Minimal	Addressed in Policy and Procedure UM 31.02 Coordination of Care with First Steps for Non-School Aged Children & for Children Receiving School-based Services and Early Intervention Services was revised to clarify that "School Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. "However, the revised Policy and Procedure has not yet been finalized or approved. During the interview, the MCO discussed at length how the Policy and Procedure Care Coordination for Passport Members also Receiving First Steps, Early Intervention Services or School-	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by approving and implementing Policy CC 30.00 - Care Coordination for Members also receiving First Steps, Early Intervention Services or School-Based IEP Services , effective April 1, 2015. Please see the Policy, attached above.

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State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	receiving these services are identified and information is shared with the early intervention/school-based service providers with appropriate permission from the parents. An audit will be conducted of the coordination of care between services providers including sharing of information with parental consent will be conducted. A minimum of 5 cases will be audited over a 3 month period of time with a performance expectation of 100%. UM 31 02 Coordination of Care \		based Services is very close to being finalized and approved. The Policy and Procedure will define the process for coordinating school-based services and early intervention services including prevention of duplicative services and coverage during treatment interruptions. The procedure is based on best practices from the Tennessee office and discussions with DMS. Since the last audit, the MCO has hired a Department of Health/School Based Services Manager to assist in efforts to enhance coordination. In order to address the knowledge deficit, the new staff member will help to educate members/parents/ guardians on the health services offered by the MCO to children during school breaks and after school. The MCO is also planning two mailings each year to each head of household to inform about school-based services and Early Intervention (EI) services. The new staff member is also tasked	

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			with conducting audits to determine if PCPs integrate information about health services received from external resources into the members' medical records to be considered in care planning. The MCO provided a copy of the audit report from February 2015. The MCO also suggested that they would also like to collaborate with other MCOs, DMS and the Department of Education to discuss sharing of claims data, which would help enhance coordination. **Recommendation for Passport** The MCO should approve and implement the Policy and Procedure.	
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	During the onsite, Passport provided a revised version of Policy and Procedure CC 4.05 Identification and Outreaching of Members for Case Management Services (updated March 2015), which addresses Pediatric Interface Services for pediatric patients	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by approving and implementing Policy CC 4.05 into the process workflows of the care coordination department.

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**
			diagnosed with life-threatening/terminal illnesses. The trigger list for Care Coordination on page 11 was updated to include life-threatening/terminal illnesses. **Recommendation for Passport** The MCO should approve and implement the revised Policy and Procedure.	CC 4.05 Identification and Ou
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.	Minimal-2013 4th Qtr QI Work Plan includes quarterly monitoring of enrollment, referral sources and outcomes of Case Management members. Quarterly reports as submitted to DMS were not provided for review. **Recommendation for PHP** Quarterly reports detailing the required reporting elements should be provided for review. **MCO Response:** Passport Health Plan respectfully disagrees with this finding of minimal. There is a discrepancy between the 2013 DMS Contract on page 150 and the Appendix K Reporting template. The Contract states to report quarterly and Appendix K states to report monthly. Passport reports this	~~Substantial~~ Full	Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results) Reports #65 and #66 were submitted for 2/2014 through 1/2015. No report was submitted for 1/2014, which is included in the review period, contract year 2014. The 2014 MCO contract requirements for Report #65 and Report #66 are described in Appendix K - Reporting Requirements and Reporting Deliverables. On page 47, the Reports are listed as "Active." On	**Passport Response:** The January 2014 reports were submitted to DMS with an incorrect header showing a different timeframe. Copies of these reports with corrected headers are attached. Guardianship Report 66 20141...

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**
	information monthly on Report 65 and Report 66 to ensure compliance. Passport is awaiting a response from DMS on the frequency of the report. Report 65 and 66 for December was provided prior to our onsite audit.as an example. Passport was unclear that documentation for the entire review period was requested. Reports for January through November are attached for review. <u>Final Review Determination:</u> No change in compliance level IPRO and DMS agree that Passport Health Plan's submission of monthly reports exceeds the requirement for quarterly reporting. However, the review period was CY 2013 and only one monthly report was submitted as evidence of compliance. At a minimum, the MCO should have provided a report for each quarter of the review period. Unfortunately, the reports provided in response to the preliminary findings cannot be accepted as evidence of compliance. Additionally, if there is any question regarding documentation that will show evidence of compliance, the MCO should contact IPRO and/or DMS during the documentation submission phase/when preparing for the onsite review. This determination was discussed with DMS.		page 112, the frequency of Report #65 is listed as monthly. On page 113, the frequency of Report #66 is listed as monthly. **<u>Recommendation for Passport</u>** Passport should ensure that Report #65 and Report #66 are submitted for each month of the contract year.	Rpt 65 Foster Care Report 2014... Reports_Attestation_140214_ReportALL.pdf **<u>DMS Response</u>** **Plan needs to be careful on dates on reports and should be accurate.**

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**
	Recommendation to DMS: In the next Contract, DMS should revise the wording to be consistent regarding the frequency of reporting. In the interim, the required frequency of reporting should be clarified for the MCOs.			

Final Findings
Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	3	2	1	2
Total Points	9	4	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			**14/8=1.75**	

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' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Case Management/Care Coordination
Suggested Evidence

Documents
Policies/Procedures for:

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

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

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

Final Findings

File Review

Care Coordination files 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

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Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
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-2014			
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Full-2014			
22.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Full-2014			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Face encounters.				
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.	Full-2014			
22.5 Member Information Materials				
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,	Full-2014			
be published in at least a 14-point font size, and	Full-2014			
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full-2014			
Font size requirements shall not apply to Member Identification Cards.	Full-2014			
Braille and audiotapes shall be available for the partially blind and blind.	Full-2014			
Provisions to review written materials for the illiterate shall be available.	Full-2014			
Telecommunication devices for the deaf shall be available.	Full-2014			

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**
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.	Full-2014			
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.	Full-2014			
All written materials provided to Members, including forms used to notify Members of Contractor actions and 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-2014			
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 Passport 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	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
styles which respect Member's cultural background.				
The Contractor shall communicate such policies to Subcontractors.	Full-2014			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	Only 1 review determination of Not Applicable			
Total Points				

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

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

Reports

Reports of outreach activities

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Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.	Full-2014			
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Substantial- Medical record confidentiality standards are included in P/P QM 5.00, although HIPAA audits are not specifically described. However, information regarding HIPAA privacy and security audits of providers is included in the Provider Manual, with audit elements and	Full	This requirement is addressed in QM 5.00 Medical Record Standards and Review.	

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**
	procedures outlined in the manual in section 4.5. Onsite staff indicated that provider audits for privacy and security are conducted in initial and onsite audits, and during quality audits and in response to complaints. Section 4.5 of the Provider Manual, which includes medical record confidentiality standards, is cited in provider audit result summary letters. **Recommendation for PHP** The plan should include audit of confidentiality standards as part of medical record standards in medical record policies/procedures. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation by adding Confidentiality standards to Passport's QM 5.00 – Medical Record and Standards Policy, see page 4. QM 5.00 - Medical Record Standards and			
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall	Full-2014			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provide 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-2014			
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:	Substantial- P/P QM 6.0 Quality and Continuity Coordination of Medical Record Review includes procedures for PCP medical record review related to continuity and coordination of care, such as information sharing between specialists and PCPs, ensuring follow-up care, and outreach following ED use. P/P QM 5.0O describes annual medical record review to address HEDIS clinical measures, Kentucky DMS outcome measures, compliance with Clinical Practice Guidelines and documentation standards including continuity and coordination of care. As per P/P QM 5.00 PCPs are reviewed once every	Substantial	QM 6.0 Quality and Continuity Coordination of Medical Record Review and QM 5.0O meet this requirement. As per P/P QM 5.00 PCPs are reviewed once every three years. During the onsite, the MCO submitted NS-13 Site Surveys and Record Audits from Avesis, which is their dental benefits subcontractor. This policy states that Avesis conducts medical record reviews of providers seeing 80% of the members covered by the MCO	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by QI revising the policy QM 5.00 to include additional specialist types and updated criteria for the random pull to include all KY providers. Currently we are completing the review for 2014 and will utilize the update criteria to pull the sample for 2015 going forward.

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	three years. Although not specifically addressed in policy/procedure, onsite staff indicated that dental providers are assessed based on trending and specialists during review of quality concerns and also during HEDIS reviews. The plan provided a summary of 2013 audit results, and evidence of review of 64 practice sites, including family practice, internal medicine, general medicine, OB GYN and pediatric practices. **Recommendation for PHP** The plan should include methodology for assessment of dental and high volume specialty providers in policies and procedures. **MCO Response:** Passport Health Plan is in the process of acting upon IPRO's recommendation by revising the Medical Record Review process. Changes to the audit process will include methodology for the assessment of dental and ancillary providers. Policies and procedures related to Medical Record Review will be updated accordingly.		every three years according to the Standards for Member Records as set forth in the Provider Manual. The MCO noted during the interview that currently only OB GYNs are included in their audit sample in addition to PCPs. There are plans to include other high-volume specialties such as cardiologists and surgeons in future audits. It was suggested that the MCO consider stratifying their random sample by county or region to ensure that providers in urban areas are not overrepresented in the audit sample. **Recommendation for Passport** The MCO should finalize and implement its plans to audit other high-volume/high-risk specialists. The MCO should consider stratifying their random sample by county or region to ensure that providers in urban areas are not overrepresented in the audit sample.	QM 5.00 Medical Record Standar...
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;	Full-2014			
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Full-2014			

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and	Full-2014			
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.	Full-2014			
27.6/27.7 Provider Maintenance of Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.	Full-2014			
The Member's Medical Record is the property of the Provider who generates	Full-2014			

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the 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).				
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:	Full-2014			
A. Member/patient identification information, on each page;	Full-2014			
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;	Full-2014			

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. Date of data entry and date of encounter;	Full-2014			
D. Provider identification by name;	Full-2014			
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Full-2014			
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);	Substantial- This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual. P/P QM 5.00 Appendix A indicates that past medical history should be documented for members seen three or more times. The importance of past medical history regardless of number of times seen, since it can impact diagnoses and therapy choice, was discussed onsite. **Recommendation for PHP** The plan should ensure that past medical history is included in all medical records regardless of number of times seen. **MCO Response:** Passport Health Plan has acted upon IPRO's recommendation. The statement of past medical history three or more times has been removed from the appendix document. QM 5.00 - Medical Record Standards and	Full	This requirement is addressed in QM 5.00 Medical Record Standards and Review.	

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
G. Identification of current problems;	Full-2014			
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;	Full-2014			
I. Documentation of immunizations pursuant to 902 KAR 2:060;	Full-2014			
J. Identification and history of nicotine, alcohol use or substance abuse;	Full-2014			
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;	Full-2014			
L. Follow-up visits provided secondary to reports of emergency room care;	Full-2014			
M. Hospital discharge summaries;	Full-2014			
N. Advanced Medical Directives, for adults;	Full-2014			
O. All written denials of service and the reason for the denial; and	Full-2014			
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.	Full-2014			

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**
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;	Full-2014			
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and	Full-2014			
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.	Full-2014			
27.7/27.8 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance	Full-2014			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.				
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-2014			
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.	Full-2014			
38.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS	Full-2014			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.				
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.	Minimal- Maintenance of the confidentiality of member information is addressed P/P PHP 23 and UM 30.0, and the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual). Policies and procedures for minors as per contract requirement were not evident in the policies and procedures or Provider Manual provided by the plan. **Recommendation for PHP** The plan should address provisions for assuring confidentiality of services for minors as per contract requirement in policies and procedures. **MCO Response:** Passport Health Plan respectfully disagrees with this finding. The supporting documentation was provided prior to the onsite. For your convenience, please find the previously submitted Policy CO 12, Personal Representative and Identity Verification of Individuals Requesting PHI that was provided prior to our on-site audit under the QAPI – Structure and Operations – Delegated Services. See page 4, Section 2.	Full	This requirement is addressed in CC 22.0 Confidentiality, Privacy and Disclosure Guidelines for Care Coordination.	

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**
	CO 12 - Personal Representatives and I <u>Final Review Determination:</u> No change in compliance level IPRO agrees that Passport Health Plan submitted policy and procedure CO 12 "Personal Representatives and Identity Verification of Individuals Requesting PHI". However, the version submitted pre-onsite was dated "Date Approved: 9/9/11" and "Reviewed 8/13/2013" while the version appended to this tool reads "Date Approved: 9/27/2013" and "Revised September 27, 2013." Additionally, neither policy specifically addresses the statutes under KRS 214.185 (e.g., specific situations in which parental consent is not required), nor do the policies address issues such as how to contact the minor Member. The "Purpose" of the P/P dated 9/2013 states "verification of identification…for Members who are unable to make decisions…" and omits "guidelines for verification of personal representative." The focus of the Contract requirement is not solely provision of consent but also ensuring information related to specific types of services provided to a minor Member without parental notification or consent is not shared. (See Contract citation below).			

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	PHP should consider adopting a P/P for these specific issues and referencing it in CO 12. *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.*			
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Full-2014			
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.	Substantial- Access to protected health information consistent with state and federal regulation is addressed in P/P UM 30.0 and PHP 23, as well as the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual). This information is included in PHP's Notice of Privacy Practices document for members that are on the plan's member website. The plan does not explicitly address relevant agencies as listed in the contract requirement in submitted policies and procedures. **Recommendation for PHP** The plan should reference persons or agencies	Full	This requirement is addressed in UM 30.0 Confidentiality and Privacy Guidelines.	

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**
	which require information to perform duties related to administration of the Department in policies and procedures. **MCO Response:** Passport agrees with the recommendation and has updated UM 30.00. The 2015 Provider Manual will be updated. UM 30 0 Confidentiality and Pr			
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-2014			

IPRO
Improving Healthcare for the Common Good

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Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	4	1	0	0
Total Points	12	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		**2.80**		

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

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (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' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Medical Records

Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Provider compliance assessment/monitoring results and follow-up

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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-2014			
33.4 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.	Full-2014			
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-V classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-V.	Full-2014			
Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record.	Full-2014			
33.5 Behavioral Health Provider Network				
The Contractor must emphasize access to services, utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and	Full-2014			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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-2014			
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.	Full-2014			
Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.	Full-2014			
To the extent that non-psychiatrists and other providers of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Full-2014			
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Full-2014			
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.	Full-2014			
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.	Full-2014			

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-2014			
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Full-2014			
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Full-2014			
It is not acceptable for an intake line to be answered by an answering machine.	Full-2014			
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:	Substantial- See sub-components below.	Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) See sub-components below.	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;	Full-2014		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
B. No incoming calls receive a busy signal;	Substantial- Addressed in DMS Report 11 and UM 62.27: "99% of calls received by Beacon will not receive a busy signal. Plan confirmed 99% but not 100%.	Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	**DMS Response** 5/1/15: This is the second year the MCO is not Fully Compliant with regards to that UM 62.67 which was replaced with UM

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for PHP Policy should be revised to address this requirement at 100%. **MCO Response:** Passport acknowledges the recommendation.		Addressed in MCO Report # 11: No calls received a busy signal for all months of 2014. UM 62.27 was replaced with UM 62.29, Member Services and Clinical Referral and Triage Process and states that 99% of calls received by Beacon will not receive a busy signal. **Recommendation for Passport** Policy should be revised to address this requirement at 100%.	62.69 mentions the 99% not 100%. Refer to Requirement letter B, Prior Results & Follow-Up Recommendation and MCO Response and EQRO (IPRO) Recommendation for this year. **Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy UM 62.29 to reflect that 100% of calls received by Beacon Health Strategies will not receive a busy signal. See page 5 of the attached Policy under Procedure. UM 62.29.docx
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;	Substantial- At least eighty percent (80%) of calls were answered within thirty (30) seconds for all months of 2013 except July (69.24%) and August (75.26%) per Evidence Compliance Hotline Requirements document. In November 2013, over ninety-four percent (94.64%) of calls were answered within thirty (30) seconds. **Recommendation for PHP** The plan should ensure that at least 80% of calls are answered within 30 seconds.	Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Addressed in MCO Report #11: At least eighty percent (80%) of calls were answered within thirty (30) seconds for all months of 2014 except August (72%) and September (65%). **Recommendation for Passport** The MCO should ensure that at least	**DMS Response** 5/1/15: This year and last year not Fully Compliant, the Recommendation for this year and last year are the same, and refer to statement for the Requirement. **Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by adding additional member service representatives to address high volume

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**
	MCO Response: Passport agrees with the recommendation.		80% of calls are answered within 30 seconds.	time periods and to make sure 80% of calls are answered within 30 seconds.
D. The call abandonment rate is seven percent (7%) or less;	Substantial- Call abandonment rate was seven percent (7%) or less for all months of 2013 except July (9.57%). In March 2013, call abandonment rate was zero percent (0%). **Recommendation for PHP** The plans should ensure that the abandonment rate is 7% or less. **MCO Response:** Passport agrees with the recommendation.	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) Addressed in MCO Report #11: Call abandonment rate was 7% or less for all months of 2014.	
E. The average hold time is two (2) minutes or less; and	Full-2014		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.	Substantial- UM 62.27, p. 5 states "calls received via Beacon's dedicated toll free telephone lines are answered live by a Member Services Representative"; clinical emergencies are referred directly to Beacon Clinician per Item #5. UM 1.21 addresses emergency situations. Beacon's automated voice prompt system does use an auto-attendant to answer calls and refer members to live person for emergencies, and also instructs member to call 911 for emergencies. The ability to "patch to 911 emergency services" was not noted in documentation or during	Substantial	The system's ability to "Patch to 911 emergency services" was not addressed in submitted documentation. Policies for handling emergency calls are not consistent. Document titled "Beacon Health Strategies Procedures for Emergent, Urgent and Routine Calls" presents separate procedures for an emergency vs. a life threatening situation. For emergency calls, the document instructs the member services representative to instruct the member to call 911 ***or*** instruct the	**DMS Response:** 5/1/15: For this year and last year the EQRO (IPRO) findings regarding, "The system's ability to "Patch to 911 emergency services" was not addressed in submitted documentation (IPRO comment this year). For MCO to refer to the Requirement, the Recommendation last year and MCO Response last year. DMS also wants to acknowledge IPRO comment, due to concern, regarding, "Policies for handling emergency calls are

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**
	interview. **Recommendation for PHP** Patch capabilities for 911 emergency services should be addressed by the behavioral health vendor. **MCO Response:** Passport agrees with the recommendation.		member to go to the nearest emergency room or hospital ***or*** instruct the member to go to the nearest location where they can seek immediate medical attention. For a life-threatening situation, the member services representative is instructed to keep the member on the phone and alert a clinician or another representative to contact a clinician to assist with the call. UM 1.26 Clinical Coverage and Access to Utilization Management Staff replaced UM 1.21. UM 1.26 states that incoming calls to Beacon may be answered in one of 5 ways including auto attendant that provides the caller with a number-based menu option. "Emergent" callers are instructed to select the first option that connects them directly to a Beacon clinician. UM 62.29 Member Services and Clinical Referral and Triage Process states that member services representatives receiving an incoming call that appears to be a clinical emergency will be referred directly to a Beacon clinician, and the clinician will respond to the member call. The policy then refers to section 5. This section states that if risk is determined to be imminent, the Beacon clinician either instructs the	not consistent." DMS wants MCO to note the Recommendations for this year by IPRO. **Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by updating Policy UM 62.29 to reflect that Member Services Representatives have the ability to patch to 911 emergency services. Member Service Representatives and clinicians are trained in the ability to patch to 911. Policies are now consistent in the processing of emergency calls, specifically the receiving and routing of calls. UM 62 29 Member Services Clinical Refe

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**
			caller to: call 911 or call 911 for the caller; go to local behavioral health emergency service; go to the nearest emergency room or hospital; or go to the nearest location where they can seek immediate medical attention. **Recommendation for Passport** The system's patch capabilities for 911 emergency services should be addressed by the behavioral health vendor. Policies should be consistent regarding procedures for receiving and routing emergency calls.	
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.	Full-2014			
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	Substantial- DMS Report 11 tracks duration, but policy does not address the requirement to not impose maximum call duration limits. During the onsite interview, the Plan stated that calls are of sufficient length to meet the member's needs. **Recommendation for PHP** Policy should be revised to include requirement to not impose maximum call duration limits. **MCO Response:** Passport agrees with the recommendation.	Full	UM 1.26 addresses this requirement.	

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Substantial- Linguistic access is documented in Member Handbook, but Hotline Cultural Competency requirements were not documented in policy. At onsite interview, Plan explained that cultural competency is a part of yearly training program. **Recommendation for PHP** Incorporate cultural competency requirements in relevant hotline policies. **MCO Response:** Passport acknowledges the recommendation.	Full	Addressed in UM 62.29.	
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.	Non-Compliance- Not addressed in documents provided either pre-onsite or onsite. **MCO Response: Passport Response:** Passport Health Plan respectfully disagrees with the finding. The supporting documentation was provided prior to our onsite. For your convenience, please find the previously submitted Behavioral Health section of the Provider Manual, page 3, 19.2 and UM 62.27 – member Services and Clinical Referral and Triage Process.	Non-Compliance	The plan did not submit documentation that satisfies this requirement. HR 60.6 includes a state specific training addendum for Texas only. Evidence of compliance with this requirement would include information regarding whether the Hotline serves multiple MCO Programs/product lines and/or multiple MCO Service Areas or if there are dedicated staff for each. Additionally, if multiple Programs/Service Areas are served by a single Hotline, evidence that the Hotline staff are knowledgeable about the various Programs, Provider Networks, and Service Areas, in particular, those related to Kentucky Medicaid.	**Passport Response:** Passport Health Plan has acted upon IPRO's recommendation by having Behavioral Health Member Service Representatives complete extensive training in each plan served by the Woburn Service Center, including Passport Health Plan. Attached are the overall training agenda, and training materials that provide information about the Plan and Provider Network, Service Areas and Kentucky's Medicaid program.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Provider Manual - Behavioral Health Cha UM 62.27 - Member Services and Clinical F This information is also covered in our Member Handbook that was supplied for a different portion of the audit. See pages 2, 26 and 27. Member Handbook - BH.pdf Final Review Determination: No change in compliance level. The documents provided do not address the requirement. The Contract indicates that the BHS Hotline may serve multiple Contractor Programs. If the Hotline serves multiple programs, the Hotline			KY Cheat Sheet update- Passport.doc MS PHP KY call flow only.xlsx 3 Week Training Program 15 day blocl Member Services Training Doc 1-15-20: Passport Behavioral Health Training for Me

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Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	staff must be knowledgeable about all Contractor Programs. The BHS Hotline may serve multiple Service Areas. If the Hotline serves multiple Service Areas, the Hotline staff must be knowledgeable about the BH Provider Network in each Service Area. The documents provided address the existence of a BHS Hotline and no need for referral/prior authorization for BHS in an emergency situation only. Evidence of compliance with this requirement would include information regarding whether the Hotline serves multiple MCO Programs/product lines and/or multiple MCO Service Areas or if there are dedicated staff for each. Additionally, if multiple Programs/Service Areas are served by a single Hotline, evidence that the Hotline staffs are knowledgeable about the various Programs, Provider Networks, and Service Areas, in particular, those related to Kentucky Medicaid.			
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full-2014			
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full-2014		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health				

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such screening and evaluation procedures shall be submitted to the Department and DBHDID for approval. The Contractor will work directly with DBHDID to introduce the evidence based tool Screening, Brief Intervention, Referral, and Treatment (SBRIT) in appropriate PCP settings.	Full-2014			
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.	Full-2014		Includes BH/PH Care Coordination file review summary results	

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 Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Full-2014			
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.	Full-2014			
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.	Full-2014			
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full-2014			
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	Full-2014			
33.9 Court-Ordered Services				

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.	Full-2014			
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Full-2014			
33.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members admitted to the state psychiatric hospital.	Full-2014			
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric	Full-2014			

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.				
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.	Full-2014			
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of 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.	Substantial- Partially addressed by KY Discharge State Facility Policy, CC 4.05 Identification of Members for Case Management, and BH Standard Compliance 4th Quarter 2013 (slide 12); there is no mention of co-occurring developmental disabilities in the documents in relation to ICM eligibility. CM KY 30 addresses general requirement but is not specific to members with co-occurring developmental disabilities. At onsite interview, plan explained that this subpopulation is covered under the general umbrella of members discharged from a psychiatric facility. ICM Program Description, p. 10, addresses "children and adolescents with serious emotional and /or behavioral disorders, but not members with co-occurring developmental disabilities.	Full	CMKY 30.2 addresses members with co-occurring developmental disabilities.	

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**
	Recommendation for PHP Modify policy and program description to explicitly mention members with co-occurring developmental disabilities. **MCO Response:** Passport acknowledges the recommendation.			
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.	Full-2014			
Appropriate follow up by the Behavioral Health Service provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.	Full-2014			
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.	Full-2014			
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.				

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:				
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-2014			
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	Full-2014			
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;	Full-2014			
D. Protect the confidentiality of Member information and records; and	Full-2014			
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full-2014			
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

Final Findings

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Behavioral Health Services

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.22**		

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' Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Findings

Behavioral Health Services
Suggested Evidence

Documents

Policies/procedures for:

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

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

Final Findings

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

Reports

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

File Review

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

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
31.1 Pharmacy Requirements				
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;	Full-2014			
B. Retrospective utilization review services;	Full-2014			
C. Formulary and non-formulary services, including prior authorization services;	Full-2014		Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports)	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere;	Full-2014			
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors; and	Full-2014			
F. Coverage for all drugs for which a federal rebate is available and has been provided by DMS.	New Requirement	Full	Policy PH 2.02, Standards for Drug Review Performed by the Pharmacy & Therapeutics Advisory Committee addresses the requirement.	
31.2 Formulary and Non-Formulary Services				
The Contractor shall maintain a preferred drug list and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.	Full-2014			

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members via posting on the web and other relevant means of communication. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.	Full-2014			
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The P&T Committee shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary. The P&T Committee shall be considered an advisory committee to a public body and thereby making it subject to the Open Meetings Law. The Contractor shall give prior notice to the Department of the time, date and location of the P&T Committee meetings.	Full-2014			
31.3 Pharmacy Claims Administration				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. The Contractor shall be responsible for processing components required for paper Claims.	Full-2014			
The Contractor maintains, through an online system, appropriate accounts receivable (A/R) records for the Commonwealth to systematically track adjustments, recoupments, manual payments and other required identifying A/R and Claim information.	Full-2014			
The Contractor shall interface with the Commonwealth's	Full-2014			

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.				
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 manufacture. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	Full-2014			
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.	Full-2014		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	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			#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)	

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Pharmacy Benefits

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:

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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