



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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	Coventry Cares has implemented a QAPI program as outlined in the QI Program Strategy 2012, QI Work Plan, UM Program Description, EQIC Description, Subcommittee and Org Chart, and policies and procedures. Monitoring, evaluating and implementing improvement interventions are also presented in the Annual QI Evaluation Report, which for the last reporting period (2011) was somewhat limited due to recent plan start-up. There has been a great deal of progress since an onsite meeting in October 2012 in implementing several initiatives and improving the quality structure. Quarterly reports, PIP report and committee minutes reveal assessment, monitoring, evaluation and improvement efforts are ongoing.	
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.		Substantial	Coventry Cares Kentucky's 2012 QI Program Strategy describes the structure and processes that the plan has implemented to monitor, evaluate and improve care and services. The strategy identifies the roles of staff and the committee structure in place to support quality initiatives. The strategy includes	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

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Final Report 9.11.13

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			<p>monitoring of key indicators such as adverse events and HEDIS measures. The plan also has policies outlining the process for monitoring of grievances and appeals, including quality of care concerns, and access.</p> <p>The QI Program Strategy indicates that the plan will annually review the assessment, analysis and implementation of interventions for member and provider grievances and appeals, cultural factors that impact members, behavioral health issues, utilization and clinical data, access and availability and network adequacy. The Work Plan outlines specific processes underway for evaluating health care outcomes, including HEDIS measures and Healthy Kentuckian measures. The plan has been monitoring monthly HEDIS administrative rates as per onsite staff and quarterly reports.</p> <p>Delegation oversight is included in the QI Program Strategy. The processes for evaluating access with regard to appointment availability are described in P/P PR-006. The plan monitors the availability of provider appointments with</p>	



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Final Report 9.11.13

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(See Final Page for Suggested Evidence)**

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			<p>secret shopper methodology; PCP calls have begun and specialist calls are scheduled to follow next quarter as per plan onsite staff. Per P/P PR-006, a percentage of PCPs are surveyed quarterly via secret shopper calls, which address urgent care, routine care, preventive care and specialty care. During the onsite meeting in October, the staff indicated that there was some concern about after-hours access and provider availability in rural areas, and that the plan was also monitoring and evaluating ED utilization and Geo Access reports. During the compliance review, onsite staff noted that mapping of urgent care centers was also undertaken.</p> <p>The Utilization Management Program Description describes processes to monitor and report sentinel events and quality of care concerns, ED Utilization and over and under utilization, including pharmacy, hospital readmission and lead screening. The Work Plan indicates tracking of adverse events and member and provider complaints and grievances (category, type intervention and turnaround times). The Summary of</p>	



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MCO: Coventry Cares

Final Report 9.11.13

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(See Final Page for Suggested Evidence)

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			<p>Quality Improvement activities report (report 16) notes the top complaints categories.</p> <p>The UM Program Description also notes that Health Services staff identifies members in need of EPSDT services. EPSDT screening rates are being monitored by the plan as documented in quarterly reports, though not noted in the QI Work Plan.</p> <p>The QI Work Plan includes analysis of the health plan population's demographic profile annually, as well as an annual cultural assessment, to prioritize QI activities as recommended by the Executive Quality Improvement Committee (EQIC). This includes high volume diagnoses.</p> <p>The QI Work Plan indicates that CAHPS surveys (adult, child and children with chronic conditions) will be conducted in 2013; annual disease management, case management and customer surveys will also be conducted.</p> <p>Health Risk Assessment (HRA) completion</p>	



KY EQRO ANNUAL REVIEW

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Period of Review: November 1, 2011 – December 31, 2012

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Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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			<p>rates are monitored by the plan.</p> <p>Member grievances and Quality of Care concerns have been noted by the plan and in review of files to have some opportunity for improvement with regard to categorization to ensure that all quality of care concerns are appropriately investigated by health care professionals and tracked.</p> <p><u>Recommendation for Coventry Cares</u> The plan should ensure appropriate identification and categorization of all member quality of care concerns, and the plan should further investigate trends of specific categories of quality of care concerns and adverse events when there are sufficient data to analyze by type (e.g. hospital acquired infections).</p>	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.		Full	The plan has implemented a QAPI program as outlined in the QI Program Strategy, the UM Program Description and various policies and procedures as outlined above. The identified purpose of the QAPI program is to monitor and improve outcomes of care, services, safety, and satisfaction and to promote	MCO Response: None



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

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			<p>culturally competent, cost effective delivery of services. The QI Work Plan outlines planned QI activities. The MCO quarterly reports include quality activity updates in an updated QI Work Plan (Report 17, Quality Assessment and Performance Improvement Work Plan). This document identifies quarterly status and activities in greater detail than the QI Work Plan.</p> <p>The QI Work Plan submitted for the review identifies targeted areas of QI activities addressed by the plan, and demonstrates planned monitoring of customer service call answering metrics, pharmacy and UM call answering metrics, UM decision accuracy, Geo Access and appointment availability, member satisfaction, complaints and grievances and appeals turnaround times. Planning for HEDIS reporting in 2013 is included in the Work Plan, and Healthy Kentuckian measures are included as categories, although no planned activities are documented. Delegation oversight, provider satisfaction, Performance Improvement Projects (PIPs) and quarterly reporting are also included as categories in the Work Plan. Many</p>	



KY EQRO ANNUAL REVIEW

March 2013

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Final Report 9.11.13

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			<p>activities have been implemented since the October 2012 onsite meeting.</p> <p><u>Recommendation for Coventry Cares</u> The plan should consider including detailed quarterly status and activities in the QI Work Plan.</p>	
<p>The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.</p>		Full	<p>As the plan has not yet reported annual HEDIS or Healthy Kentuckian data, QI activities linked to evaluation findings are somewhat limited. The plan has not yet had access to an EQR annual evaluation, accreditation reviews or findings from annual HEDIS indicators and member surveys.</p> <p>The plan does provide evidence of internal surveillance and of metrics including customer service and other call metrics, HRA completion, complaints and grievances and adverse events, and EPSDT screens, as well as utilization metrics. One of the more commonly identified adverse events is documented to be hospital acquired infection, which could be further analyzed regarding root cause when more data are available.</p>	



**KY EQRO ANNUAL REVIEW
March 2013**

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MCO: Coventry Cares**

Final Report 9.11.13

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

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			<p>Quality of care issues per policy are tracked, analyzed and referred to appropriate committees (QM/UM, Peer Review and Credentialing), and meeting minutes include discussion of potential quality concerns.</p> <p>PIP proposal submissions had strong rationales that included analysis of the plan's utilization metrics showing high ED use and a medication possession ratio demonstrating suboptimal adherence to antidepressants.</p> <p>HRA completion rates were noted to be low, and the plan has implemented a work group to address this issue with their vendor as per onsite staff. This is an important initiative, since the HRA is an important component of plan activities, such as outreach to smokers for cessation assistance.</p> <p>EPSDT rates were noted to be low, and the plan has implemented an EPSDT toolkit, EPSDT training modules for providers, feedback regarding members missing screens and an EPSDT audit tool.</p>	



KY EQRO ANNUAL REVIEW

March 2013

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MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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			<p>The plan conducted a medical record audit that revealed BMI and Advance Directives to be areas with opportunity for improvement; this feedback was given to providers.</p> <p>The plan identified several interventions that would be undertaken in response to provider survey results.</p> <p>The plan has implemented an asthma program for providers.</p> <p>MCO quarterly reports indicate that an action plan will be implemented for Geo Access if needed. The plan indicated that a contract was initiated with a Federally Qualified Health Center (FQHC) to improve access, and other initiatives including increasing urgent care center access and surveying providers regarding accepting members out of panel.</p>	
The QAPI program shall be developed in collaboration with input from Members.		Full	The updated QI Program Strategy updated 11/26/12 notes that member input will be solicited in various ways including through satisfaction surveys. The CAHPS survey is underway at the time of the review. The plan cites voiced concerns of members regarding barriers to care in the rational	



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March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
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Final Report 9.11.13

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

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			for their Performance Improvement Project (PIP) regarding Emergency Department (ED) utilization. The QI Program Strategy identifies the Quality and Member Access Committee (QMAC) as a subcommittee of the Executive QI Committee, and the purpose of the committee is to obtain feedback from members on marketing materials, customer service, network access, benefit interpretation, and the health plan overall. While the first QMAC meeting in April 2012 was informational, minutes from subsequent meetings in September and December 2012 reflect these activities and input from members on the QAPI program. Discussions included an overview of QI and HEDIS measures, review of the Member Handbook and Provider Directory, and discussion of PIPs. Members provided input on the plan's website, and a question and answer period is documented.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.		Full	Minutes were provided for QMAC meetings from 4/25/12, 9/12/12 and 12/19/12. Minutes included topics discussed as noted above, including Performance Improvement Projects (PIPs) and member comments. Member-voiced	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

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Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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			<p>concerns are noted in the rationale for the PIP proposal as noted above, and the plan is in the process of conducting CAHPS surveys. The plan tracks member concerns (complaints and grievances) as noted in the Work Plan, and member complaints and grievances receive acknowledgement/resolution letters.</p> <p>The plan included a customer service survey response in their complaints files. The member had forwarded a complaint regarding medication coverage, and the plan responded to this member's input.</p> <p>As per the QI Program Strategy, members can access a copy of the QI Program Strategy through Customer Service.</p>	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.		NA	The plan is preparing for NCQA accreditation, and the QI Work Plan notes an anticipated NCQA accreditation as of 2014. The plan is involving all departments in preparation, and EQIC minutes reflect ongoing preparation for accreditation.	
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,		NA	Not applicable; the plan has not yet begun the NCQA accreditation process.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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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.				
Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.		Full	The QAPI program description was outlined in the document QI Program Strategy 2012, dated 7/25/12 and updated 11/26/12; the strategy was submitted to DMS 7/30/12 as per the QI Work Plan and EQIC minutes.	
As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.		Full	The QI Program Strategy indicates that members' behavioral health needs are provided for and behavioral health and physical health services are coordinated to improve identification and care for members with behavioral health needs. Behavioral health services are integrated into the plan and QAPI program, and behavioral health and physical health are coordinated at the plan level and individual case level. Administration and management of behavioral health services (mental health and substance abuse) is undertaken by MHNNet, an NCQA accredited Managed Behavioral Health Care Organization (MBHO). MHNNet is Coventry owned. Behavioral health	



KY EQRO ANNUAL REVIEW

March 2013

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MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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			<p>quality improvement activities and utilization management are delegated to MHNet, but behavioral health and physical health actively work together on PIPs and other initiatives (e.g. substance abuse among pregnant women and behavioral health-physical health continuity of care). The plan and MHNet hold regular operational meetings to monitor performance as per quarterly reports.</p> <p>There is behavioral health representation on the Executive Quality Improvement Committee (EQIC) and Quality Management/Utilization Management (QM/UM Committee. EQIC and QM/UM minutes include discussion of behavioral health issues, such as adoption of behavioral health guidelines.</p> <p>MHNet behavioral health care advocates are co-located at the health plan to integrate treatment and case management activity, and they interact with physical health case managers to coordinate care and address comorbidities. The collocation also facilitates referrals between behavioral health and physical health.</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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			<p>The QI Program Strategy notes that members are surveyed for mental health status in multiple existing quality programs. There are weekly Coventry Cares/MHNet team meetings and case management rounds, which also offer opportunity for nurses to interact with MHNet staff and Medicaid pharmacists as per the Annual Evaluation.</p> <p>The plan monitors behavioral health utilization indicators as per quarterly reports, and is working to clarify other indicators. The plan conducted behavioral health member surveys in 2012.</p>	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.		Minimal	<p>The plan documented working on behavioral health and physical health coordination initiatives, including substance abuse among pregnant women and depression management by PCPs. Onsite staff discussed tracking of referrals, PCP prescribing and depression screening. The plan did not provide reports of indicators relevant to behavioral health/physical health integration. The annual evaluation notes priorities for 2012 to include oversight of delegated services, including monitoring and improvement of</p>	<p>MCO Response: CoventryCares understands the importance of integrating behavioral health with physical health, and is committed to this important health initiative. CoventryCares is collaborating with its behavioral health subcontractor, MHNet, to ensure optimal outcome and continuity of care in the member's treatment related to major depression, pregnancy and drug abuse. This is partially accomplished through integration of MHNet and CoventryCares Case Managers in case rounds for those members needing both physical and behavioral health assistance..</p> <p>A focus study to address substance abuse in pregnant women and prevent medical conditions among newborns was</p>



**KY EQRO ANNUAL REVIEW
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**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

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			<p>behavioral health care delivery.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>proposed in late 2012. This is a collaborative project between Case Management, MHNet (behavioral health vendor), Medical Affairs, and Quality Improvement (QI). Prenatal substance abuse is a major public health concern nationally, and more specifically in Kentucky, and has potentially severe consequences for the user and their child. Substance abuse is defined as a pattern of excessive use of an illicit substance, such as drugs (marijuana, cocaine, heroin, methamphetamines, etc.), alcohol or nicotine and the over or misuse of prescription medications. Baseline data has been collected and community resources beyond case management are being explored. A workgroup has been established; goals and objectives have discussed and proposed. The full study proposal has been written and discussed to be implemented in year 2013. Please refer to attached proposal titled, "Focus Study-Substance use in pregnancy final 4.18.13."</p> <p>In addition, case rounds that include MHNET and case management personnel for members having both physical and behavioral health concerns began in May 2013. Minutes are kept of the case rounds.(Minutes are available upon request).</p> <p>Our Performance Improvement Project (PIP) for Major Depression and Antidepressant Medication Management and Compliance is also working to address this issue and has progressed significantly in 2013. Please note, this PIP was updated and approved by the Department for Medicaid Services in December 2012. As a result, just a small data set was available for the EQRO review period. The interventions, monitoring and evaluation are occurring in 2013. In</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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(See Final Page for Suggested Evidence)**

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				<p>coordination with our behavioral health vendor, MHNNet, Case Management (CM), Provider Relations, the Pharmacy Director and the Medical Director are working on the following activities and initiatives since January of 2013:</p> <p>--Interdepartmental workgroup meetings started in December 2012 and are ongoing monthly. Minutes are taken and participants include QI, Outreach, Provider Relations, Case Management, Health Services, Medical Affairs and MHNNet, our behavioral health vendor. (Minutes available upon request).</p> <p>--The Academic literature search and strategies (PIP intervention #8) were implemented in collaboration with the Pharmacy Director and QI staff in January 2013. The goal of the collaboration is to develop strategies and identify literature to educate providers and assist them with educating their members regarding the adherence, response time to the medication, and the risks of premature discontinuation.</p> <p>--A targeted letter and brochure for 236 members was mailed in late January 2013 on the importance of following their treatment plan. Members were identified using the 2013 HEDIS methodology defined as members 18 years and older with a diagnosis of major depression and were newly treated with antidepressant medication.</p> <p>--The CoventryCares of Kentucky website is being enhanced to better educate members. The website will include a Behavioral Health link to the National Institute of Mental</p>



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

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				<p>Health (NIMH) website for depression. CoventryCares will use the member tab to provide members with educational information regarding the identification, diagnosis, and importance of management of major depression.</p> <p>--A PIP document library has been created. The library contains all the documents relating to the Major Depression Disorder (MDD) PIP (i.e. approved provider and member correspondence, reports etc.)</p> <p>--Kentucky transportation information has been distributed to all employees and members of CoventryCares and MHNet. The transportation resource information will assist members with their transportation needs.</p> <p>--The Major Depression Disorder (MDD) PIP Intervention Tracking Tool has been created. The PIP Intervention Tracking Tool is a "living document" providing a current snapshot of all PIP activities tracking the internal flow process for referrals from CoventryCares Case Management (CM medical) to MHNet (behavioral services). Tracking will be ongoing. Updates will be presented to the MDD workgroup monthly.</p> <p>--Ongoing collaboration between CoventryCares and MHNet included the development of a tool for tracking mailings to members who receive education regarding depression and post partum depression. Results of the trackings are presented to the MDD workgroup monthly.</p>



**KY EQRO ANNUAL REVIEW
March 2013**

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				<p>--Development of a member educational packet to be mailed to members identified in the above tracking report. The packet includes a targeted member letter, <i>Following Your Treatment Plan</i> and <i>First Aid Tips</i> brochures, and a non-emergency room facts magnet.</p> <p>--Collaborated with the Quality Management and Compliance Committee (QMAC) for educating members in the community about major depression. This included a meeting in Georgetown, Kentucky on 3/31/2013. The MHNNet keynote speaker's topic was "Mental Health Medication and Therapy."</p> <p>--HEDIS reports and Medication Possession Ratio rates evaluated monthly and will be reported in the next state quarterly report (please refer to report 19)</p> <p>--A total of 841 letters with brochures for following your treatment plan were sent to members in May 2, 2013, and 130 mailers to non-compliant members on May 30, 2013.</p> <p>We will continue our interventions and evaluation per our PIP work plan (please refer to PIP interventions outlined in the proposal), and a full evaluative report will be submitted to the state in September 2013 with HEDIS results.</p> <p>IPRO Comments: No change in review determination.</p>
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the		Full	The Annual Evaluation of the Quality	MCO Response: None



KY EQRO ANNUAL REVIEW

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Final Report 9.11.13

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<p>overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes. 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 by July 31 of each contract year.</p>			<p>Improvement Program (Annual Review of Activities 11/1/11-12/31/11) was conducted after the plan had been in operation for two months, and is included in the Work Plan as an activity that will be conducted at the end of 2012. The 2011 Annual Review is dated 7/31/12. This evaluation includes an analysis of KY and Coventry population demographics. For the health plan, children ages 18 or less comprised 61% of the population, special needs (SSI) 17.8% and dual eligible 13%. An analysis of high volume episodes by diagnosis and place of service is also included; the top 20 diagnoses for high volume episodes include hypertension, asthma, diabetes and COPD. These conditions were therefore targeted for disease management. High risk OB was also identified as high volume.</p> <p>Abandoned calls and speed to answer were reported in the evaluation, and were noted to exceed the target in December; this was attributed to new staff and start up, and continued monitoring was planned. There were few other indicators to report, given the short time that the plan had enrolled members; few</p>	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
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Final Report 9.11.13

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

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			<p>complaints and grievances had been reported. Some examples of adverse events were included in the evaluation, and it is noted that these will be tracked and trended.</p> <p><u>Recommendation for Coventry Cares</u> The plan should consider root cause analysis of common adverse events.</p>	
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.		Substantial	As per the plan's 2012 QI Program Strategy, Coventry participates in annual reviews and provides access to the site, information, documentation and dates for review to the EQRO. The plan provided most of the requested information for the annual compliance review; some information, such as Health Risk Assessment files, was not provided for review onsite or immediately thereafter. The plan provided PIP proposals and revised proposals as requested for PIP validation. Though not yet applicable, the corporate plan also reviews the annual EQRO evaluation, provides comments for improvement and implements EQR recommended corrective actions as per	MCO Response: None



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>the Program Strategy.</p> <p><u>Recommendation for Coventry Cares</u> The plan should provide requested documentation in a timely fashion for future reviews.</p>	
<p>The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.</p>		Full	<p>As per the QI Program Strategy, the plan actively participates in EQR activities. The health plan cooperated and participated in the evaluation of quality program review in October 2012, annual compliance review 2013 and the PIP validation process. The plan had key staff available for the onsite review, and staff was actively engaged in the process. The plan submitted PIP proposals, and engaged in conference calls to discuss findings and recommendations from review of the PIP proposals, and revised the PIPs based on recommendations.</p>	
21.4 EQR Administrative Reviews				
<p>The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical</p>		Substantial	<p>As per the QI Program Strategy and P/P QI-002, the plan provides information as requested for EQR activities. The plan provided most information requested as noted above; however, Health Risk Assessment member files that were</p>	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

**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
chart review shall be the responsibility of the Contractor.			requested were not provided for review. <u>Recommendation for Coventry Cares</u> The plan should ensure complete submission and availability of requested documentation.	
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.		Substantial	As above, the plan assisted in EQRO reviews and evaluation. Some requested files and documents were not provided. <u>Recommendation for Coventry Cares</u> The plan should ensure complete submission and availability of requested documentation.	MCO Response: None
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	The initial PIP proposals were not accepted by DMS, and the plan revised the proposals as per the timeline established during conference calls. The plan has not yet had opportunity to respond to findings of the compliance review.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;		NA	EQR compliance review findings have not yet been provided to the plan. The assignment of a staff person to conduct review findings follow-up is included in P/P QI-002. Responsible parties for PIP reviews	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
			were identified.	
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		NA	EQR compliance review findings have not yet been provided to the plan. As per P/P QI-002, the Quality Manager informs the Quality Management Committee of EQRO findings and will develop, implement and monitor a corrective action plan.	
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.		NA	This is included in the QI Program Strategy and P/P QI-002. The plan has not yet had opportunity to respond to findings.	
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		NA	The QI Program Strategy describes the plan's participation (corporate participation is noted) in the annual external quality review, and includes implementation of corrective actions as per recommendations. The QI Work Plan includes cooperation with EQR activities. The QI Work Plan notes resubmission of PIP proposals based on EQR recommendations and formation of interdepartmental work groups to address PIPs. The plan has not yet had opportunity to review annual compliance review findings.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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. If contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.		NA	This is included in P/P QI-002. The plan has not had opportunity to review EQRO findings for the annual compliance review.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that		Full	The plan submitted the CoventryCares of Kentucky QI Work Plan 2012 (the Work Plan) final 7/25/12 updated 11/27/12.	
outlines the scope of activities and		Full	Initiatives are listed in the Work Plan, with rationale and description of methodology for conducting and measuring initiatives.	
the goals,		Full	The Work Plan includes specific goals.	
objectives, and		Full	The Work Plan includes specific objectives.	
timelines for the QAPI program.		Substantial	Reporting frequencies are included in the Work Plan. Dates are included in the Work Plan, but it is not clear whether these are target dates for completion or dates that activities were completed. <u>Recommendation for Coventry Cares</u> The Work Plan should include anticipated timelines for the Program as well as completion dates. Responsible parties are identified in the work plan.	MCO Response: None
New goals and objectives must be set at least annually based on findings from quality improvement activities		NA	The Work Plan was finalized 7/25/12, and activities and status are updated quarterly	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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 studies, survey results, Grievances and Appeals, performance measures and EQRO findings.			<p>in quarterly reports. There are few findings available as of yet, as the plan has not yet reported annual measures, conducted surveys or received findings from the EQRO review. The QI Program Strategy indicates that recommendations will be developed based on annual review of the QAPI program.</p> <p>Committee minutes provide evidence of tracking and trending grievances and appeals and adverse events. As per EQIC minutes, the plan has set goals for appeal overturn rates. The plan is monitoring monthly HEDIS indicators, although annual results are not yet available to set goals.</p> <p>Interventions were outlined in response to Provider Survey results.</p>	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;		Full	As per the QI Program Strategy, the Board of Directors has delegated oversight of the QI Program to the Executive Quality Improvement Committee, and responsibilities include review and approval of the QI Program Description and Work Plans, including updates to Work Plans, as per the QI Program Strategy and EQIC Responsibilities-2012 document provided by the plan. The EQIC	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
			approved the QI Program Strategy and QI Work Plan on 7/25/12 as reflected in minutes and the QI Work Plan. Discussion of the updated QI Work Plan is also evident in committee minutes and the Work Plan.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;		Full	The Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of Coventry Cares of Kentucky. As per the QI Program Strategy, the board has delegated oversight of the plan's Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC). The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer and includes members of senior leadership. The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. The Vice President of Medical Affairs (Medical	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Director) is the senior executive responsible for the Quality Improvement Program as per the QI program Strategy. The Regional Vice President of Quality Improvement provides direction on activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;		Full	The EQIC Description, Committees and Org Chart document provided by the plan notes that the EQIC reviews the QI Program Description, Work Plan and updates, and Annual Evaluation, and is responsible for monitoring delegated services and activities of other committees. As noted above, the Board of Directors annually reviews the Program Description, Work Plan and Program Evaluation, as described in the QI Program Strategy, and the EQIC reports to the Board of Directors as per the QI Program Strategy. The EQIC reviewed and approved the 2012 Quality Improvement Work Plan, Quality Improvement Program Strategy and the 2011 QI Program Evaluation on 7/25/12 as per meeting minutes. The plan also provided EQIC meeting minutes for	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>March, June, July, August and September 2012 for review.</p> <p>The 9/27 EQIC minutes indicates that the EQIC will receive biannual reports from each committee and that programs not meeting goals will be discussed in committee. The plan provided a detailed schedule of reports due from the QM/UM Committee and Service Advisory Committee. The agenda for the 11/2012 EQIC meeting notes that the EQIC will review grievances and appeals, however minutes were not provided for this meeting. The EQIC also reviewed and approved PIP proposals on 8/29/12.</p>	
review on an annual basis of the QAPI program; and		Full	As per the QI Program Strategy, the EQIC reviews and approves the QAPI program evaluation. The minutes of 7/25/12 reflect approval of the 2011 QI Annual Review by the EQIC. The EQIC also reviews the program strategy and Work Plan as documented in committee minutes.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.		Substantial	As noted in the QI Program Strategy, the EQIC reviews quality improvement studies, surveys, indicators and intervention and makes program recommendations based on findings. The QI Work Plan reports 17	MCO Response: None



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>submitted quarterly include activities and interventions based on findings of monitoring activities. Areas addressed include customer service call metrics, access, high level complaints and grievances and sentinel/adverse events. Other activities are noted for EPSDT and other quality indicators in quarterly reports. Since there was little to report in the 2011 annual program evaluation due to the short timeframe of member enrollment, the 2012 Program Strategy had little to incorporate from the annual program evaluation. HEDIS and Healthy Kentuckian indicators have not yet been reported.</p> <p>Some areas of concern such as Health Risk Assessment completion, access issues in some regions of the state, and EPSDT screening rates did not have corresponding activities noted in documents provided. Some activities reported onsite, though not yet included in the Work Plan, include addressing access by mapping and increasing urgent care centers and identifying providers who would take members out of panel; formation of a work group regarding</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Health Risk Assessments; development of EPSDT report cards for providers and an EPSDT training module; and providing feedback to providers on a medical record audit. Some of these activities are documented in committee minutes and others occurred after the review period.</p> <p><u>Recommendation for Coventry Cares</u> The plan should ensure these activities are included in future Work Plans.</p>	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.		Full	<p>As per the QI Program Strategy and EQIC Description, Subcommittee and Org Chart document, and as noted above, the Board has delegated oversight of the plan's QI program to the Executive Quality Improvement Committee (EQIC). The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. All quality improvement activities and subcommittee recommendations are</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>reported to the EQIC for assessment, development, implementation and monitoring of activities. Several subcommittees are identified in the QI Program Strategy, including the Quality Management/Utilization Management, Service Advisory, Compliance, Credentialing, Quality and Member Access, and Pharmacy and Therapeutics Committees; these committees routinely report to the EQIC. The EQIC Description, Subcommittee and Org Chart document and EQIC meeting minutes document that the EQIC monitors all aspects of the QAPI Program.</p> <p>As per the Program Strategy, the Quality Management/Utilization Management Committee (QM/UM) is the committee that provides clinical input and physician review of QI and UM programs and provides recommendations for the programs to the EQIC. The Vice President of Medical Affairs chairs the QM/UM committee. Minutes reflect clinical review of the QI and UM programs.</p>	
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		Full	As per the QI Program Strategy, and as reflected in minutes, the EQIC is comprised of senior leadership staff across	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.</p>			<p>departments who are involved in QI Program activities, such as the VP of Medical Affairs, Health Services, Compliance, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals. Participation across departments is evident in committee minutes. The QM/UM Committee is the subcommittee of the EQIC that includes physician representation; in addition to two plan medical directors, three network providers and MHNet are represented on the committee. QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation. Onsite staff noted that representation from obstetrics/gynecology was still being recruited. Network provider input was evident in committee minutes. The QM/UM committee had its inaugural meeting September 20, 2012 and met monthly thereafter in 2012.</p> <p><u>Recommendation for Coventry Cares</u> The plan should continue attempts to recruit an obstetrics representative.</p>	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.</p>		Full	<p>The plan provided agendas and minutes for EQIC meetings from March 28, June 13, July 25, August 29 and September 5, and September 27 of 2012. An agenda was provided for November 14, 2012, although meeting minutes were not. The QM/UM committee met initially on September 20, 2012 and monthly thereafter in 2012; meeting minutes were provided for QM/UM meetings on September, October, November and December of 2012.</p>	
<p>QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.</p>		Full	<p>Reports of QI activities relevant to providers are reported to the EQIC annually or more frequently as per the EQIC Description, Subcommittees and Org Chart, and the EQIC is responsible for integration these activities related to providers as well delegation oversight. Minutes of the QM/UM Committee include multiple examples of QI activities relevant to providers and subcontractors, such as clinical guideline dissemination, evaluation of dental decay data, medical record audit for BMI and advanced directive documentation, creation of EPSDT toolkits and audit forms, MHNNet training materials and plans for hospital site visits to discuss criteria for utilization reports. The Provider Manual includes</p>	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>requirements for provider agreement to participate in quality improvement activities including site visits and medical record audits and encounter record submission. These are included in the Provider Manual for delegated services as well. As documented in the QI Program Strategy, the Compliance Committee oversees subcontractor relationships and also oversees the Delegation Oversight Committee. The first meeting of the Delegation Oversight Committee occurred on 9/27/12 as per EQIC minutes, and this committee reports to the EQIC. Minutes for this committee meeting were not provided. Behavioral health has its own quality program, but appears well integrated with physical health as described above.</p> <p>Quarterly report 15 in the second quarter documents feedback to the dental, behavioral health and pharmacy subcontractors regarding compliance and grievances and appeals. As per the encounter data questionnaire submitted to the EQRO, Coventry conducts audit and validation of provider claims. Evidence of feedback to providers was provided in</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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/UM minutes (medical record audits)	
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.		Full	The plan's QI Work Plan, QI Program Strategy and UM Program Description include Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities. Provider Credentialing is incorporated into QI activities relative to quality of care concerns and adverse event monitoring. Provider Services is part of QI activities outlined in the QI Work Plan. Evidence of inclusion of these management activities is also present in EQIC minutes and member lists.	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of Member's care and services, including those with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.		Full	The local MCO QI team is noted in the QI Program Strategy to include the Vice President of Medical Affairs, plan medical directors, the Manager of Quality Improvement, four QI Coordinators and one QI Analyst. Case Management, Medical Management and Member Appeals staff also participates in QAPI activities. The Regional VP of Quality Improvement for the Medicaid Region (Kentucky, Michigan and Missouri) is active in EQIC meetings, and as per EQIC minutes oversees the Kentucky Quality Improvement management team. During	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>onsite discussion in October, the plan identified an EPSDT Case Manager as a key vacancy; this position has now been filled as per onsite staff during the compliance review. The Behavioral Health Director and Medical Director and behavioral health care advocates are co-located at the health plan. The health plan staff includes a social worker behavioral health-physical health liaison. The plan has onsite hospital concurrent reviewers. Corporate plan resources include Medical Directors, Corporate VP of Quality, QI Managers, IS support and Member Services as per the QI Program Strategy. Regional resources include the Vice President of QI, Director of Quality and HEDIS Manager.</p> <p>Coventry Cares meets actively with corporate staff. Monitoring and evaluation is effectively implemented as described below.</p>	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care,		Full	The Annual Program Evaluation, quarterly reports and committee minutes provide evidence of ongoing monitoring of quality of care. Enrollment in Disease Management and Case Management is	MCO Response: None



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>			<p>monitored, and gaps in care for members with chronic conditions or missing services are monitored by the plan as per quarterly reports. Relevant HEDIS measures will also be monitored for these members. The plan is monitoring substance abuse among pregnant women and antidepressant medication management. The plan has begun monitoring monthly administrative HEDIS rates, as per plan staff onsite, although reports were not available for review. The plan monitors Geo Access, EPSDT screens, Health Risk Assessment completion, utilization data and member complaints and grievances. The plan conducted an audit of provider documentation of BMI and Advance Directives. Activities have been implemented relative to the findings. The plan is to begin provider appointment availability secret shopper calls in 2013.</p> <p>The plan will begin to implement a Key Performance Indicator log to establish baseline data, which will be reviewed by the EQIC. Indicators for this log include Customer Service and Language line Access, Member and Provider Grievances and Appeals, Network Additions and</p>	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Credentialing, Authorizations, Utilization – bed days, average length of stay, readmission rates, high volume diagnosis, Utilization by place of service, ER Utilization, Case Management access and case intensity levels, Outreach initiatives, Disease Management enrollment by disease category, Adverse Events and Quality of Care concerns.</p> <p>The plan's P/P QI-009 outlines monitoring, investigation and trending of adverse events from a variety of sources, and the QI Work Plan documents that adverse events and potential quality of care concerns are tracked, trended and reported annually. There is evidence of monitoring of quality of care concerns and sentinel events in committee minutes. Committee minutes for the EQIC indicate that improvement of coding of quality of care concerns is being worked on to improve trending ability, since currently it is difficult to identify trends. Quarterly reports also indicate that appeal overturn rates are monitored and as per committee minutes, the top ten appeals will be evaluated. CAHPS member survey will be conducted in 2013.</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>The plan has analyzed member demographic data and diagnosis prevalence to prioritize quality improvement activities and focus disease management programs as per the QI Program Evaluation.</p> <p>The QI Work Plan includes monthly monitoring of customer service and pharmacy call metrics (abandonment, speed of answer), nurse line calls, and utilization management calls (prior authorization), and these appear to be actively monitored.</p> <p>As per MCO quarterly report 18, behavioral health network provider: enrollee ratios and service utilization are being tracked. The plan is working on clarification for some behavioral health metrics.</p> <p><u>Recommendation for Coventry Cares</u> The plan should continue work on improving trending of quality of care concerns by improving categorization and monitoring detailed types of concerns.</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.		Full	Clinical and preventive guidelines are included in the EQIC Description and QI Program Strategy. EQIC and QM/UM committee minutes include discussion of clinical guidelines. The plan presented USPSTF Preventive Health Guidelines to the EQIC on June 13, and behavioral guidelines were reviewed by the EQIC on 8/29/12. The QM/UM committee discussed disease management guidelines, notification of providers regarding these guidelines and ADHD guidelines as per committee minutes. The QM/UM committee at the 9/20 meeting conducted peer review, and quality of care concerns and adverse events are investigated and evaluated by the plan Medical Director. The plan has conducted a medical record audit of BMI documentation and Advance Directives, and began monthly monitoring of HEDIS measures, which will be reported in June 2013. Provider compliance with guidelines monitoring will include monitoring of HEDIS measures as per the QI Program Evaluation.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.		Full	A medical record chart audit was conducted for BMI and Advance Directive documentation, with feedback given to providers. HEDIS measures, which will be	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
			used to assess provider compliance with guidelines, have not yet been reported. However, as per quarterly report 18, providers are being informed of members with gaps in services based on monthly monitoring of selected HEDIS measures. As per QM/UM minutes, providers with referrals for Quality of Care concerns or adverse events are being tracked and trended. The plan identified that customer service calls did not meet goals, and actions and interventions planned were outlined in the activity summary of the Work Plan in quarterly reports. The plan indicated that EPSDT report cards for providers were being developed, and QM/UM Committee minutes indicate that an EPSDT audit form is being developed. EPSDT rates were noted to be below goal, and the plan implemented automated calls and mailings to address the low screening rates. A Health Risk Assessment (HRA) work group has been formed to address HRA completion. Areas with opportunity for improvement are noted in the Annual QI Evaluation, with associated improvement activities.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The		Full	Effectiveness of interventions is monitored by ongoing tracking of indicators and	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Contractor shall perform reevaluations to assure that improvement is sustained.			provider quality referrals as noted above and as described in quarterly reports. There were no distinct provider-related corrective actions that appeared to be identified and monitored by the plan in the submitted documentation or discussion.	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.		Full	The plan's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff. The QM/UM committee, which reviews and analyzes clinical data, includes pediatric, internal medicine, hospital and behavioral health members, as well as Case Management, Appeals, Health Services and Pharmacy representation. The plan is engaging all departments as it plans for HEDIS reporting. As per the QI Program Strategy, there is computer/data and clinical/professional staff at the local plan level and also at the corporate level to augment local staff for QI activities as per the QI Program Strategy. The behavioral health PIP is being conducted by a team that includes both MHNnet and	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
			plan staff.	
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	At the time of the review, the plan had submitted quarterly MCO reports through January 2013 and two PIP topics, one behavioral health focused (Major Depression) and one physical health focused (Emergency Department Utilization). PIP activities are reported in quarterly reports number 19. PIP revisions as per EQR and DMS recommendations were submitted by the plan.	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.		Substantial	As per the QI Program Strategy, the plan's evaluation of the QAPI Program includes evaluation of utilization and clinical performance data against evidence based practice. The Provider Manual describes clinical guidelines and where to locate them on the plan's website. The process for development, approval and distribution of review guidelines was described in the first quarterly reports #23, Evidence Based Guidelines for Practitioners. The plan did not provide a specific policy relevant to the development or adoption of clinical practice guidelines. Clinical review guidelines are included in	MCO Response: None



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>the UM Program Description, which notes that they are available on request and are disseminated on the provider website, provider manual and provider newsletters.</p> <p>Committee minutes provide evidence of discussion of clinical practice guidelines. EQIC minutes of 7/25 include a report on an annual review of preventive health guidelines by the corporate Quality Team, and note that these guidelines are distributed to plans. The QI Work Plan includes annual review of clinical practice guidelines by the QM/UM Committee with recommendations to EQIC. Per the Work Plan, this review was completed by the EQIC in June of 2012, although the QM/UM Committee first met 9/20/12. QM/UM Committee minutes of 9/20 reflect discussion of Disease Management guidelines and planned voting on the guidelines by members; per the Work Plan these were distributed to providers on 9/30/12. ADHD guidelines were also discussed by the QM/UM. Preventive Health Guidelines are documented in the QI Work Plan as approved by the EQIC 6/27/12 and distributed to providers on 9/30/12. Per the QI Work Plan, the</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>immunization schedule is also annually reviewed and distributed to PCPs and posted in the member and provider handbook. An updated immunization schedule adopted by EQIC on 8/29/12 was noted to be disseminated via provider website and provider notification via FAX as per meeting minutes. MHNet reviews behavioral health guidelines annually; these were approved by the EQIC on 8/29.</p> <p><u>Recommendation for Coventry Cares</u> The plan should consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines.</p>	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;		Full	The Provider Manual describes the adoption of nationally recognized guidelines by the plan and sources such as the American Academy of Pediatrics. The plan references USPSTF preventive health guidelines and behavioral health guidelines adopted from the American Psychiatric Association (APA) in committee minutes and quarterly reports. USPSTF preventive health guidelines were presented to the EQIC June 13, 2012. The UM Program Description documents the	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
			use of InterQual guidelines for clinical decision-making. This document also indicates that medical necessity is determined based on scientifically based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by Coventry. An updated immunization schedule was approved by EQIC on 8/29/12.	
consider the needs of Members;		Full	The UM Program Description notes that guidelines used in UM decision-making may be modified to consider an individual member's characteristics. EQIC minutes of 7/25 document updated Corporate Quality Team recommendations for dyslipidemia screening in children, dental education, gonorrhea screening, iron deficiency anemia screening, screening for hearing loss and tuberculosis testing. These guidelines are relevant to plan Medicaid membership. QM/UM Committee minutes include discussion of clinical guidelines such as ADHD, which are based on members' needs. Disease Management programs, which have associated guidelines, were prioritized according to prevalence of conditions among plan membership.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
developed or adopted in consultation with contracting health professionals, and		Full	The QI Program Strategy indicates that the QM/UM committee, which includes contracting health professionals, will review guidelines. The QM/UM meeting minutes include discussion clinical guidelines. Preventive health guidelines were approved by EQIC prior to the initial QM/UM meeting. MHNnet reviews behavioral Health guidelines prior to EQIC approval.	
reviewed and updated periodically.		Substantial	<p>Committee minutes of the EQIC note that clinical practice guidelines are reviewed and updated annually by corporate Quality; local plan policy on guidelines review and adoption was not provided. The QM/UM minutes note that disease management guidelines are updated annually. EQIC minutes of 7/25 and 8/29 note updated preventive guideline recommendations and immunization schedules.</p> <p><u>Recommendation for Coventry Cares</u> The plan should consider policies/procedures regarding development, adoption, dissemination and updating of clinical practice guidelines.</p>	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

**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
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.		Full	The plan employs InterQual guidelines and other scientifically based guidelines from national medical research, professional medical specialty organizations or governmental agencies for UM decision making as per the QI Program Strategy, QI Program Evaluation and Provider Manual. National guidelines are also employed for disease management, which includes member education, as per QM/UM 9/20/12 minutes.	
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.		Minimal	<p>The plan provided information on its Text 4 Baby program. The plan also provided text describing lower levels of behavioral health care including Intensive Outpatient Programming (IOP) and Partial Hospitalization (PHP) to allow members to transition to outpatient care or avoid hospitalization.</p> <p>Reports on the plan's program to improve and reform the pharmacy program management were not provided for review. The plan provided text that use of generic drugs is promoted in the plan's formulary, and has successfully increased generic drug dispensing rates.</p>	<p>MCO Response: CoventryCares of Kentucky has a Policy (PHM – 002) that provides criteria for the formulary. One of the criterion for a drug to be added – as long as safety and efficacy are comparable – is cost. Drugs that have lost patent protection and are available as generics will be selected under this criteria. Kentucky Pharmacy Law and claims processing logic mandates that the lowest cost generic be dispensed when a prescription is written for a product that has lost patent protection. These elements combine to drive market share to generics.</p> <p>As proof of the efficacy, market share – as shown in the Pharmacy Monthly Dashboard – for CoventryCares of Kentucky grew from 81.5% in March, 2012 to 86.4% in March, 2013.</p>



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>IPRO Comments: No change in review determination.</p>
20.1 Kentucky Outcomes Measures and HEDIS Measures				
<p>The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix O, 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.</p>		Full	<p>The plan has not yet reported Kentucky outcomes or HEDIS measures. However, the plan has begun activities targeted to these measures as reported in quarterly reports 18 and 17. The plan has also begun monthly monitoring of HEDIS measures and implemented a work group for HEDIS reporting. The QI Work Plan includes Healthy Kentuckian performance measures Adult and Child BMI and counseling, cholesterol screening, adolescent screening, prenatal risk assessment and CSHCN as well. EQIC minutes of 6/13/12 indicate that seven measures have been targeted for interventions for improvement, including</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>"childcare" visits, cervical cancer screening, BMI, and prenatal/postpartum. These targeted measures are further discussed in EQIC 8/29 minutes, where it is noted that EPSDT reminders will address well visits, and that 20 providers contributing to these measures will be targeted for intervention. The QI Work Plan also includes monitoring of the HEDIS measures controlling high blood pressure, annual dental visit, well child visits, lead screening and access to PCPs as per "HEDIS timeframes". MHNnet is working with PCPs regarding Antidepressant Medication Management. Non-compliant members are being identified for HEDIS measures, and members who are missing services are being identified for providers.</p>	
<p>Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.</p>		NA	NA; measures not yet reported	
<p>The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.</p>		NA	NA; the plan was provided with specifications for Individuals with Special Health Care Needs (Children and Adolescents) Access and Preventive Care,	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
			but has not yet reported on this measure, provided feedback or worked collaboratively as of yet on measure development.	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.		NA	NA; the plan has not yet reported the health outcome measures.	
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.		NA	While the workgroup has not yet set performance targets and goals, the QI Work Plan includes a category related to Kentucky performance measures Adult and Child BMI and counseling; cholesterol screening, adolescent screening, prenatal risk assessment and CSHCN. Quarterly report 18 is specific to activities regarding performance measures and report 17 is specific to Work Plan activities updates; these reports were submitted for 2012 on 4/30/12, 7/30/12 and 1/30/13. An annual report of performance measure data and demographic stratification was not yet available for review, as they will be reported in 2013.	
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report		NA	The plan is scheduled to report HEDIS	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
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 31 st .			<p>measures for the first time in 2013. The plan indicated during the onsite meeting that monthly administrative HEDIS rates were currently being run and tracked; reports were not provided for review. Preparations for HEDIS reporting include HEDIS meetings and engagement of other plan departments. August 29 EQIC minutes note that the plan is developing a HEDIS culture, with participation of all departments in HEDIS.</p> <p>There is a corporate HEDIS team in place, and the plan staff can access the Navigator system to build on provider HEDIS information. As per the QI Work Plan, HEDIS activities are scheduled for 2013, including a HEDIS audit and reporting.</p>	
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.		NA	NA; measures not yet reported.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category,		NA	NA; measures not yet reported.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
race, ethnicity, gender and age.				
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	NA; measures not yet reported.	
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	NA; measures not yet reported	
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		NA	NA; the plan has not yet undergone the NCQA accreditation process or audit. NCQA accreditation is planned for 2014.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
Recommendations and History to the Department in accordance with timelines established by the Department.				
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	The plan is preparing for NCQA accreditation, and the QI Work Plan notes an anticipated NCQA accreditation as of 2014.	
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 characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed.		Full	The two topics that were submitted 9/1/12 were not accepted by DMS due to lack of focus. The plan ultimately chose Major Depression and ED Utilization as PIP topics. The re-submitted PIP proposals address the relevance of the topics to the plan membership very well, and the topics are challenging to address and were approved by DMS/EQRO. Major Depression is prevalent, and ED utilization is a noted problem area for the plan that may indicate access problems. The plan considered potential disparities in care in the proposal. The PIP topics were approved by the EQIC and the QM/UM committees.	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and		Full	The plan's P/P QI-005 outlines the process for PIPs, including types of projects	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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 that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to members and providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.</p>			<p>(clinical and non-clinical), prioritizing topics to address specific needs of members and subsequent to population analysis, interventions, and monitoring status. The plan monitors quality and appropriateness of care and services through performance measures, surveys and medical record audits as described above and in P/P QI-005. Other than the two PIP topics described above, which are based on some monitoring of plan performance with regard to antidepressant adherence and ED utilization, there were no specific PIPs undertaken. Interventions include member and provider education and case management. Payment to providers was not part of planned interventions. The plan is addressing the entire plan membership and the subpopulation of members with depression, and is planning to evaluate potential disparities in care among subgroups of members with depression.</p>	
<p>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.</p>		Full	<p>This is included in P/P QI-005. As reported in the second quarter's MCO reports, the plan's case managers collaborate with local health departments, school based</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.			health centers and community health care resources in coordinating care. These reports also note that case management staff collaborates with the Department for Child Based Services (DCBS) by presenting care plans if there are newly identified health problems and communicating with the state's regional case workers. Case Management also refers to the Commission for Children with Special Health Care Needs as applicable. Quarterly reports also note that the plan uses community resources such as shelters for outreach to the homeless population. The plan's Community Outreach Coordinators serve on homeless coalitions as well. As reported by onsite staff, MHNet is partnering with community mental health centers.	
The Department and 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	The plan provided documents and staff for the October onsite meeting and compliance review, and has been responsive to DMS comments regarding PIPs. The plan is using State-provided historical encounter data to identify high risk members.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs		Full	The plan submitted two PIP proposals that are relevant to the plan's population and	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>			<p>evaluation of plan data as noted in the rationale. PIPs address both behavioral health and physical health. The topics include Major Depression and ED Utilization. The annual statewide PIP has not yet been conducted, and not other PIPs have yet been required.</p>	
<p>The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix N.</p>		Full	<p>The plan initially identified topics for each of the four areas identified by the Department; after clarification, the plan submitted two proposals, one addressing Major Depression and the other ED Utilization, which were approved by the Department.</p>	
<p>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</p>		Full	<p>The plan submitted their PIP proposals on the template provided by the Department, and the proposals were approved. P/P QI - 005 includes the elements below.</p>	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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
conclusions drawn:				
A. Topic and its importance to enrolled members;		Full	Topic relevance was well described in each revised PIP.	
B. Methodology for topic selection;		Full	Rationale for the topic selection included statewide and plan-specific data to justify topic selection in each revised PIP.	
C. Goals;		Full	Goals were established for each revised PIP.	
D. Data sources/collection;		Full	Data sources and collection procedures were described for each revised PIP.	
E. Intervention(s) – not required for projects to establish baseline; and		Full	Interventions were described for each PIP initially that were somewhat passive and generic. Subsequent revisions included updated interventions that were active and targeted to the topic.	
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.		NA	Results are not yet available for the PIPs.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;		NA	NA; proposal only submitted. This is included in P/P QI-005.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
B. Did Members participate in the performance improvement project?		NA	NA; proposal only submitted. However, members are targeted for interventions in both PIPs.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;		NA	NA; proposal only submitted.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;		NA	NA; proposal only submitted.	
E. Is there an executive summary;		NA	NA; proposal only submitted.	
F. Do illustrations – graphs, figures, tables – convey information clearly.		NA	NA; proposal only submitted.	
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 predetermined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement		Full	The plan identified appropriate indicators based on HEDIS measures for the two PIP proposals that were submitted; goals were established and benchmarks from national data were identified in the rationales. Other relevant indicators, such as Medication Possession Ratio for adherence, are also included in the proposals.	
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:		NA	NA; proposal only submitted.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.		Full	The original proposals were submitted to DMS on September 1, 2012.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.		NA	NA; proposal only submitted.	
C. 1 st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.		NA	NA; proposal only submitted.	
D. 2 nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.		NA	NA; proposal only submitted.	
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.		Full	The plan has established a Quality and Member Access Committee as a subcommittee of the EQIC. The committee's membership includes members and consumer advocates. There are regional quarterly meetings of the QMAC. Onsite staff referenced a member advisory committee that meets at least twice a year; and acts as an ad hoc focus group.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The plan provided QMAC minutes from 2/25/12, 9/12/12 and 12/19/12. The plan provided membership lists that include members, individuals from advocacy groups and community groups.	
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. Responsibilities of the Committee shall include:		Full	As per the QMAC Committee Description, membership will be consistent with plan population with regard to these factors. Meetings are held at different regional locations to facilitate regional representation. Membership lists reveal a variety of communities represented.	
A. Providing review and comment on quality and access standards;		Full	This is included in the QMAC Committee Description. The role of the QMAC is to give feedback on topics such as marketing materials, customer service network access, benefit information and the health plan overall. QMAC minutes reveal review of the plan's provider directory, provider network status, and overview of QI, HEDIS measures and EPSDT standards.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;		Minimal	This is included in the QMAC Committee Description. Evidence of QMAC review and comment on grievance and appeals policy and process was not available for review. <u>Corrective Action Plan</u>	MCO Response: As part of CoventryCares' quarterly Executive Improvement Committee (EQIC) meetings, the Appeals Department submits Quarterly Appeals and Grievance reports. These reports reflect the totals, trends, and key indicators in the data that are necessary to track the success of the department and the compliance with state/federal



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>regulations. The Appeals Manager is responsible for presenting an overview and analysis of the data which is heard by the EQIC committee, and feedback is offered as needed.</p> <p>Please refer to attached policies, procedures, reports and minutes. Please note, the appeals and grievances reports with discussion are reflected in the EQIC minutes, not the Quality Member Access Committee (QMAC) minutes as identified in the EQRO report. Please refer to the attached EQIC minutes that reflect the reports, discussion, and follow-up. Please note, the follow-up action noted at the November 2012 meeting was reported at the February 2013 meeting (enclosed).</p> <p>Actions for improvement based on the findings and analysis of the 2012 grievances include; weekly CSO calls to discuss issues for how complaints are loaded and handled in the data system, and established action plans for necessary improvements and education; education to the grievance team on how to code issues appropriately; report on a quarterly basis numbers and types of grievances, along with analysis to outline key areas for improvement; work with provider relations to educate providers, and contract with those out of network when possible; work with the QI department for best practices in coding grievances correctly; establish a new electronic filing system for grievances so that we can ensure better compliance with letters and documentation; new processes designed to verify that correct letters have gone out, the correct department is resolving issues, and that resolution letters are sent out on all</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				<p>complaints; implement a new Quality Check tool for Grievances (verifies that we are compliant with all guidelines set forth by the Commonwealth of Kentucky and other regulatory bodies); update our data reports to more accurately measure timeframes and to identify complaints consistent with the definition in our policies and procedures.</p> <p>IPRO Comments: No change in review determination. It is noted in Section 19.4 that the plan monitors grievances and appeals. This contract requirement (20.5B) refers to review and comment on the grievance and appeal process by the QMAC.</p>
C. Review and provide comment on Member Handbooks;		Full	This is included in the QMAC Committee Description. QMAC minutes of 12/19/12 include evidence of QMAC review and comment on Member Handbooks.	
D. Reviewing Member education materials prepared by the Contractor;		Full	This is included in the QMAC Committee Description. QMAC minutes of 12/19/12 include member feedback on the plan's website. The QMAC discussed educational materials on 4/25 and the requirement for translation and sixth grade reading level.	
E. Recommending community outreach activities; and		Full	This is included in the QMAC Committee Description. Community activities and the role of Community Outreach Coordinators were discussed on 4/25/12.	
F. Providing reviews of and comments on Contractor and		Full	This is included in the QMAC Committee	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Department policies that affect Members.			Description. The QMAC minutes reveal review of member surveys and PIPs, Enhanced Case Management, Provider Representatives, and translation and interpreter services.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.		Full	The plan submitted a list of participating members in the second quarterly MCO reports. The plan submitted membership lists for April 2012, September 2012 and December 2012.	
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 Provider Satisfaction survey was conducted in 2012, and a report was provided. As per onsite staff and as reflected in the EQIC minutes and quarterly reports, the plan implemented a Transactional Survey initiated by CSO representatives, who send a web link to the provider, and a modified version (Health Plan Survey) sent to providers via fax blast. A planned member survey (CAHPS) is documented in the QI Work Plan for 2013.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.		Full	The QI Work Plan includes providing a copy of the CAHPS survey tool to NCQA and the EQIC in 2013; the plan indicated	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

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			that all documents were approved by the Department in January 2013.	
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.		Substantial	The plan has not yet conducted special member surveys, although surveys of members regarding Health Services are referenced in the UM Program Description. Onsite staff indicated that a behavioral health member survey had been conducted. <u>Recommendation for Coventry Cares</u> The plan should ensure that the need for special surveys that target subpopulations perspective and experience is assessed.	MCO Response: None
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's current provider satisfaction survey tool.		Full	The QI Work Plan indicates that the 2012 provider survey tool was submitted to DMS on July 30, 2012. The plan provided a report of the survey that included survey items.	
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.		Full	The QI Work Plan indicates that the 2012 provider survey tool was submitted to the Department on July 30, 2012 and member survey documents were approved in January 2013.	
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,		Full	The plan provided a copy of the Provider Satisfaction Survey report; this report included methodology, response rates,	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement

(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
the 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.			and survey items. Member survey documents were approved by the Department in January 2013 as per the plan.	
All survey results must be reported to the Department, and upon request, disclosed to Members.		Full	The Provider Satisfaction Survey report was provided by the plan. At the time of review, the member survey has not yet been conducted. There was no documentation of a request for survey results by members.	
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	As per the QI Program Strategy, quarterly status reports will be provided to the Department. Quarterly status reports, including an updated QI Work Plan, Quality Activity Summary, Indicator Monitoring, PIP status, Committee Activity, activities addressing EPSDT and pregnant women, and other required reports were submitted to DMS for 2012.	
Reference the following documents for further information: Appendix K Appendix N Appendix O				



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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	64	9	3	0
Total Points	192	18	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		213/76=2.80		

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



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
24. General Requirements for Grievances and Appeals				
The Contractor shall have a grievance system in place for Members that includes a grievance process related to "dissatisfaction" and an appeals process related to a Contractor "action," including the opportunity to request a State fair hearing pursuant to KRS Chapter 13B.		Full	Coventry Cares has a grievance system in place for members, with the grievance process outlined in P/P APP-004; grievances are described as written or oral expressions of dissatisfaction and cover quality of care, quality of service and administrative/service center issues. As per this policy, Customer Service, Provider Relations, Quality Improvement and Appeals departments all work collaboratively on grievances. P/P APP-004 differentiates inquiry regarding a claim status or eligibility from a grievance. The process for member appeals is outlined in P/P APP-002, with expedited appeals described in APP-001. P/P APP-002 outlines the process for requesting a State fair hearing, and how Customer Service should direct members requesting a State fair hearing. The grievance system is described in both the Member Handbook and Provider Manual. Procedures related to quality of care grievances are outlined in P/P QI-014. P/P APP-005 addresses procedures for	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			coordination of grievances and appeals relevant to subcontractors.	
The Contractor shall implement written policies and procedures describing how the Member may submit a request for a grievance or an appeal with the Contractor or submit a request for a state fair hearing with the State. The policy shall include a description of how the Contractor resolves the grievance or appeal.		Full	P/P APP-004 outlines how a member may submit a request for a grievance by phone or written communication, and member appeals processes are documented in APP-002 and APP-001 (expedited appeals). These policies include the processes from receipt of grievance or appeal to resolution. As described in P/P APP-004, categorization of member concerns are determined by Customer Service representatives, who identify whether the concern is to be categorized as an inquiry, grievance or appeal and determine the specific category of a grievance, i.e. quality of care, quality of service or service.	
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.		Substantial	As per P/P APP-003, providers may contact the Appeals Department of Customer Service to file a grievance or appeal; providers who contact Customer Services will be educated regarding how to file an appeal and assisted as necessary. The process for provider grievances and appeals is also outlined in	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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			<p>the Provider Manual. The Provider Manual describes the process for filing an appeal on a member's behalf, but does not appear to address filing a grievance on a member's behalf. The Member Handbook does indicate that a provider can file a grievance on a member's behalf with written consent. P/P APP-003 indicates a provider may file an appeal on member's behalf.</p> <p><u>Recommendation for Coventry Cares</u> The plan should include the process for filing a grievance on a member's behalf in the Provider Manual.</p>	
<p>The Contractor shall make available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.</p>		Full	<p>As per P/P APP-004, Customer Service will assist members as needed with forms, including interpreter services. The Member Handbook includes information regarding how members can obtain assistance with filing a grievance or appeal, as well as information regarding the availability of interpreter services and toll free number with TTY-TTD. Policies addressing interventions for communication barriers (MC-006, MC-002 and MC-005) outline procedures for</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			assisting members with communication barriers.	
The Contractor shall name a specific individual(s) designated as the Contractor's Medicaid Member grievances or appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.		Substantial	<p>P/P APP-004 identifies the Quality Department as responsible for quality of care concerns, Provider Services for quality of service concerns and all other grievances are the responsibility of the Appeals and Grievances departments.</p> <p>P/Ps APP-004 and APP-002 identify the Appeals Coordinator in the Appeals and Grievances Department as responsible for member notifications and preparing the file for review by the appeals committee; the Appeals Coordinator is also responsible for grievances related to benefits, claims or services and for member notification regarding decisions for these grievances as well as quality of service grievances. The Customer Service representative is identified as responsible for identifying to which category a grievance belongs, and also for determining whether a dispute is eligible for an appeal and informing the member of timeframes if Customer Service receives the call as per APP-002. As noted above, Customer Service</p>	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

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			<p>representatives also identify if a complaint is a quality of care concern or quality of service concern. Quality of service concerns are tasked to Provider Relations as per APP-004, and as per P/P QI-014, potential quality of care concerns are entered into the plan's Navigator system and are forwarded to the QI Department.</p> <p>P/P APP-004 indicates that management staff meets every week to review grievances to ensure appropriate triage and categorization and summarize trends. Findings are reported to the Executive Quality Improvement Committee (EQIC) to evaluate, track and trend the root cause of dissatisfaction. Trending of appeals does not appear specifically addressed in appeals policies, though included in Quality Improvement and UM documents.</p> <p><u>Recommendation for Coventry Cares</u></p> <p>With some overlap of responsibility of Customer Services and Appeals Coordinator, and some issues with member notifications and</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
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			categorizations as well as lack of clear documentation of resolution in some grievances forwarded to other departments as described below, the plan should clarify roles and ensure coordination of staff so that categorizations are appropriate and consistent, and complete member notification and resolution occurs.	
The Contractor shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:		Substantial	P/Ps APP-001 and APP-002 specify that Appeals Committee members cannot be involved in prior review or decision making. This is also stated in P/P APP-005 regarding subcontractors' grievances and appeals. For one EPSDT appeal file provided on the second day of review, there was no appeal documentation in the file (no oversample for EPSDT). For all other grievances and appeals where applicable, individuals making decisions were not involved in previous review or decision making. <u>Recommendation for Coventry Cares</u> The plan should ensure that appeal files are complete and that individuals	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			making decisions on appeals have appropriate clinical expertise.	
A. An appeal of a Contractor denial that is based on lack of medical necessity;		Full	P/Ps APP-001 and APP-002 document that clinical appeals (medical necessity) will be reviewed by the Appeals Committee that includes 1 to 3 health care professionals with appropriate clinical expertise. 14 of 15 member appeals and 1 of 10 provider appeals were appeals of denial based on medical necessity; all were reviewed by appropriate health care professionals.	
B. A Contractor denial that is upheld in an expedited resolution; and		Full	The Kentucky Medical Director reviews requests for expedited appeals and the Appeals Committee includes health care professionals for clinical appeals as per APP-001. There was one case file of expedited appeal reviewed; this was reviewed by a health care professional.	
C. A grievance or appeal that involves clinical issues.		Substantial	Reviews of appeals based on clinical issues are reviewed by appropriate health care professionals as documented in APP-001, APP-002 and APP-005. As noted above, all files documenting appeals involving clinical issues were reviewed by appropriate health care	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>professionals. As per P/P APP-004, grievances that are phoned into Customer Service are determined to be quality of care concerns, i.e. based on treatment rendered, by the Customer Service representative. Written grievances are handled by the Appeals Coordinator in the Appeals and Grievance Department. Once determined to be a quality of care concern, the grievance is forwarded to the QI Department. Examples of quality of care issues in this policy include medical mismanagement, treatment delay, failure to provide timely equipment, medication or referral, inappropriate delayed response to recommended care and unauthorized release of PHI.</p> <p>As per QI-014, quality of care concerns are reviewed by the Quality Improvement Coordinator. If the case cannot be closed by the QI Coordinator, the grievance is referred to a physician reviewer, who may refer the case to the Quality Management/Utilization Management Committee. According to P/P AP-004, management staff meets</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>weekly to assess complaints and grievances and determine appropriate categorization, triage and resolution, with trends reported to the Quality Committee and Executive Quality Improvement Committee periodically. The plan's schedule of committee reports indicates quarterly reporting of grievances, and committee minutes reflect this reporting.</p> <p><u>Grievance File Review</u> Of 30 member grievances and 15 provider grievances, there were 3 member grievances and 6 grievances that were identified as provider grievances that may have had a clinical component, although it was not entirely clear from the documentation. Three of these cases do not appear to have been reviewed by clinical staff (although documentation is not always clear.</p> <p><u>Recommendation for Coventry Cares</u> The plan should ensure that quality of care concerns are reviewed by appropriate clinical staff, and that documentation of investigation and</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			resolution is coordinated between the Customer Services, Provider Services, Appeals and Quality Improvement Departments, so that appropriate investigation and resolution can be tracked.	
The Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.		Full	Information regarding filing a grievance or appeal and the process is outlined in the Member Handbook. The Handbook also contains information regarding the right to request a state fair hearing. Fair hearing information is also included in resolution letters KYGA00008 (denial upheld) and KY GA00011 (partial approval). As per P/P APP-002, for members who contact Customer Service with dissatisfaction with an action, the member is educated on the right to appeal and the process for appealing.	
The Contractor shall ensure that punitive or retaliatory action is not taken against a Member or service provider that files a grievance or an appeal, or a provider that supports a Member's grievance or appeal.		Minimal	The Member Handbook includes language that providers are not punished for supporting expedited appeals. Otherwise, submitted documents (policies, Member Handbook and Provider Manual) do not appear to include language that punitive action will not be taken against a Member or service provider who files a grievance or	MCO Response: Grievance and Appeal policies (APP-001, 002, 003, 004, 005, 006, and 008) have been updated to state that no punitive action or retaliation will be taken towards a member or provider in response to an appeal. This is not limited to the expedited appeal process. Policies have been submitted to the Policies & Procedures Committee for review and approval. Copies



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>appeal.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>of the draft policies are included.</p> <p>IPRO Comments: No change in review determination.</p>
24.1 Grievance Process				
A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.				
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member.		Minimal	P/P APP-004 indicates that a member may file a grievance within 30 calendar days after the event, and that a grievance can be submitted by the member, authorized representative or provider on their behalf by phone fax written communication or electronic communication. In P/P APP-004 it is noted that written or verbal member consent is needed for a representative to file a complaint on behalf of a	<p>MCO Response: Policies APP-002, 003, 004, 006, and 008 have been updated to state written consent is required to for an appeal or grievance filed on behalf of the member. (The contract states an oral appeal or grievance may be made but it must be followed in writing.) Policies will be reviewed and adopted by the Policies and Procedures Committee.</p> <p>IPRO Comments: No change in review</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>member, rather than written consent. The Provider Manual includes the written consent requirement for filing appeals for members, but grievances are not addressed. It should be noted that there was one case file in the provider grievance sample that appeared to be a complaint by a home health provider on behalf of the member regarding home care. There was no consent documentation in the file, although it is not clear if the complaint was pursued, since the only documentation other than the complaint was a note requesting a review.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	determination.
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that		Minimal	Written acknowledgment of receipt of the grievance within five days, to include	MCO Response: CoventryCares of Kentucky has made many improvements to the



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 grievance has been received and the expected date of its resolution.			<p>expected resolution date, is included in P/P APP-004, and is to be sent by the Customer Service Representative or Appeal Coordinator. This information is also included in the Member Handbook.</p> <p><u>Grievance File Review</u> Of 30 reviewed grievance files:</p> <ul style="list-style-type: none"> • 7/30 files included an acknowledgement letter with expected resolution date sent within 5 working days. • 1/30 cases had an acknowledgement letter with expected resolution date sent more than 5 working days after receipt. • 9/30 files included an acknowledgment letter that did not reference a resolution date, but rather had language thanking the member for keeping in touch. • 2/30 files included a notation that an acknowledgement letter was sent within five days, but there was no copy of the letter in the file so content (expected resolution date) could not be reviewed. • There were 10/30 files with no acknowledgment letter or mention of 	<p>Grievance System in 2013. Improvements include:</p> <ol style="list-style-type: none"> 1) Implementation of Quality Check tool for Grievances. Management performs the Quality Check weekly. Metrics are submitted to senior management to review and identify corrective action, as needed. 2) A team member has been assigned to be fully responsible for handling Grievances. Remaining team members are full trained in handling Grievances for back-up and during the principal employee's leave. This individual dedicates their time to tracking grievances and ensuring timeliness, compliance, and quality. 3) A Tracking Log has been created to track issues opened as complaints but not worked as complaints. The Tracking Log assists the Grievance and Appeals manager in identifying issues related to staff training for the Grievance and Appeals team as well as the call center staff. Issues are reported to the appropriate department's management to reinforce appropriate handling of



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>letter. Five of these cases documented phone calls with members. In one case, the complaint was resolved on the same day but there was no acknowledgment letter or resolution letter. Some cases had very sparse documentation. One of these cases had a notation that the member should be told to appeal after calling to complain about misinformation on a denial letter, but there is no other documentation in the file.</p> <ul style="list-style-type: none"> The remaining 1/30 files noted that an acknowledgment should be sent, but there was no documentation that it was sent and no copy of a letter. <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>issues.</p> <p>4) The person responsible for grievances will use daily grievance reports to monitor inquiries coded as grievances, and issues that require action. If any complaint is closed that does not contain all of the necessary components, the case will be reviewed and either re-coded correctly, or will be re-opened as a complaint and acknowledged. This report will be viewed by the Manager and Coordinator to make sure nothing is missed. A weekly report will also be sent to the grievance coordinator so they can double check the closures.</p> <p>IPRO Comments: No change in review determination.</p>
The investigation and final Contractor resolution process for		Minimal	Resolution of grievances within 30	MCO Response: CoventryCares of Kentucky



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
grievances 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.			<p>calendar days of the date of receipt is included in P/P APP-004, and the resolution is to include a resolution letter to the grievant. As per P/P QI-014, this timeframe applies to a quality of care investigations also.</p> <p><u>Grievance File Review</u> Of 30 reviewed member grievance files:</p> <ul style="list-style-type: none"> • 14/30 were clearly resolved within 30 calendar days with a written resolution letter. • There were 5/30 cases with written resolution notices that were sent >30 calendar days after receipt of the grievance. • There were 3/30 cases noted to be resolved within 30 days, but there was no documented resolution letter. A notation indicated that a message was left on an answering machine for one case, and another case was resolved on the same day. • For 8/30 files, there was no written resolution notice and no clearly documented resolution date, and in some cases no clear resolution. <p>In some cases documentation was very</p>	<p>has made many improvements to the Grievance System in 2013. Improvements include:</p> <ol style="list-style-type: none"> 1) Implementation of Quality Check tool for Grievances. Management performs the Quality Check weekly. Metrics are submitted to senior management to review and identify corrective action, as needed. 2) A team member has been assigned to be fully responsible for handling Grievances. Remaining team members are full trained in handling Grievances for back-up and during the principal employee's leave. This individual dedicates their time to tracking grievances and ensuring timeliness, compliance, and quality. 3) A Tracking Log has been created to track issues opened as complaints but not worked as complaints. The Tracking Log assists the Grievance and Appeals manager in identifying issues related to staff training for the Grievance and Appeals team as well as the call center staff. Issues are reported to the appropriate department's management to



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>sparse. In some cases the complaint may have been handled by Provider Services or Quality Improvement, but there is no evidence in some of the available files as noted above that the complaint was resolved, resolved in a timely fashion and the member notified. P/P APP-004 indicates that the complaint research and resolution should be thoroughly detailed in comments once the complaint is resolved by the appropriate department.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>reinforce appropriate handling of issues.</p> <p>4) The person responsible for grievances will use daily grievance reports to monitor inquiries coded as grievances, and issues that require action. If any complaint is closed that does not contain all of the necessary components, the case will be reviewed and either re-coded correctly, or will be re-opened as a complaint and acknowledged. This report will be viewed by the Manager and Coordinator to make sure nothing is missed. A weekly report will also be sent to the grievance coordinator so they can double check the closures.</p> <p>IPRO Comments: No change in review determination.</p>
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the		Minimal	This is included in appeal P/Ps APP-001 and APP-002, but there is no reference to extension in the grievance policy APP-004. The plan did provide a sample letter informing the member of the need for	MCO Response: Grievance policies (APP-003,004) have been updated to include the 14 day extension language. Letters KYGA00001 and KYGA00013 (extension letters) are being updated through the



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Member written notice of the reason for the extension within two working days of the decision to extend the timeframe.			an extension for grievance investigation. The sample letter states that more information is needed from the member; there does not appear to be space to describe other reasons for the extension. Of reviewed grievances, there were none for which an extension was requested. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	plan's letter workgroup to reflect the reason for the extension. The letters will be submitted the Department for approval as required by our contract. IPRO Comments: No change in review determination.
Upon resolution of the grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B above, unless the resolution of the grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following:		Minimal	Per P/P APP-004, the Appeals Coordinator is responsible for a resolution letter. P/P APP-004 indicates that even for Provider Relations-investigated Quality of Service issues, the resolution letter is sent out by the Appeals Coordinator. Of 30 member grievances, 19 files included documentation of a resolution letter as	MCO Response: CoventryCares of Kentucky has a process that handles a Quality of Service complaint through our provider relations department and Quality of Care complaints through our Quality Improvement department. Policy APP-004 and QI-014 are consistent with this process.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>noted above. P/P QI-014 indicates that the QI Coordinator sends out member resolution letters for quality of care concerns.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>In order to improve out instances of compliance, we have made the following changes to the Grievance system:</p> <ol style="list-style-type: none"> 1) Implementation of Quality Check tool for Grievances. Management performs the Quality Check weekly. Metrics are submitted to senior management to review and identify corrective action, as needed. 2) A team member has been assigned to be fully responsible for handling Grievances. Remaining team members are full trained in handling Grievances for back-up and during the principal employee's leave. This individual dedicates their time to tracking grievances and ensuring timeliness, compliance, and quality. 3) A Tracking Log has been created to track issues opened as complaints but not worked as complaints. The Tracking Log assists the Grievance and Appeals manager in identifying issues related to staff training for the Grievance and Appeals team as well as the call center staff.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				<p>Issues are reported to the appropriate department's management to reinforce appropriate handling of issues.</p> <p>4) The person responsible for grievances will use daily grievance reports to monitor inquiries coded as grievances, and issues that require action. If any complaint is closed that does not contain all of the necessary components, the case will be reviewed and either re-coded correctly, or will be re-opened as a complaint and acknowledged. This report will be viewed by the Manager and Coordinator to make sure nothing is missed. A weekly report will also be sent to the grievance coordinator so they can double check the closures.</p> <p>IPRO Comments: No change in review determination.</p>
A. All information considered in investigating the grievance;		Full	Information considered is included in P/P APP-004 and sample grievance and quality of service decision letters	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			provided by the plan. <u>Grievance File Review</u> Of the 19/30 cases with a resolution notice, 19/19 included information considered in investigation.	
B. Findings and conclusions based on the investigation; and		Full	Investigation findings are included in P/P APP-004 and sample grievance and quality of service decision letters were provided by the plan. <u>Grievance File Review</u> Of the 19/30 cases with a resolution notice, 19/19 included findings based on investigation.	
C. The disposition of the grievance.		Substantial	Disposition is included in P/P APP-004 and sample grievance and quality of service decision letters provided by the plan. Of the 19/30 cases with a resolution notice, 19/19 included the disposition. One disposition was somewhat unclear; the member had been billed by a hospital that refused to bill Coventry. The notice indicated that the hospital had that right. The notice did not provide clarification on the implication for the member, and the member called to clarify weeks later.	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for Coventry Cares</u> The MCO should ensure that all member concerns are addressed.</p>	
24.2 Appeal Process				
An appeal is a request for review by the Contractor of a Contractor action.				
A. An action for purpose of an appeal is:				
(1) the denial or limited authorization of a requested services, including the type or level of service;		Full	This definition is included in P/Ps APP-001 and APP-002.	
(2) the reduction, suspension, or termination of a previously authorized service;		Full	This definition is included in P/Ps APP-001 and APP-002.	
(3) the denial, in whole or in part, of payment for a service;		Full	This definition is included in P/Ps APP-001 and APP-002.	
(4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or		Full	This definition is included in P/Ps APP-001 and APP-002.	
(5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.		Full	This definition is included in P/Ps APP-001 and APP-002.	
(6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.		Full	This definition is included in P/Ps APP-001 and APP-002.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
B. The Contractor shall mail a notice of action to the Member or service provider. The notice shall comply with 42 CFR 438.10(c) regarding language and (d) regarding format and shall contain, but not be limited to, the following:		Substantial	<p>Notice of action content is described in P/P UM-008, Notice of Action.</p> <p><u>Appeal File Review</u> Of 15 member appeals, one EPSDT appeal did not contain documentation in the file and there was no EPSDT oversample. This file could not be reviewed for notice of action. The 14/15 remaining files included a notice of action. 10/10 provider files included notice of action.</p> <p><u>Recommendation for Coventry Cares</u> The plan should ensure that appeal files include complete documentation and that the notice of action is included.</p>	MCO Response: None
(1) the action the Contractor has taken or intends to take;		Full	<p>This content is included in UM-008 Notice of Action policy, as well as appeals policies APP-001 and APP-002, and sample appeal notification letters provided by the plan. Of 14 member files with a notice of action, all had action taken included, and 10/10 provider files included action taken.</p>	
(2) the reasons for the action;		Full	<p>This content is included in UM-008 Notice of Action policy and policies APP-</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			001 and APP-002. The reason for the action was included in the 14 member files with a notice of action and 10/10 provider files.	
(3) the Member's or the service provider's right, as applicable, to file an appeal of the Contractor action through the Contractor;		Full	This content is included in UM-008 Notice of Action policy. Of 14 member files and 10 provider files with a notice of action, all included the right to appeal.	
(4) the Member's right to request a state fair hearing and what the process would be;		Full	The right to request a State hearing and the process to do so are included in adverse action (denial) appeal letters and partial approval appeal letters. 14/14 member appeal files with a notice of action included the right to request a state fair hearing and the process in the notice of action. All adverse appeal decision letters also include this information.	
(5) the procedures for exercising the rights specified;		Full	As per P/P UM-0008, the notice of action includes the appeal process. This was included in 14/14 member files with a notice of action. The State fair hearing process is included in adverse or partial appeal determination letters as well.	
(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and		Full	Circumstances for expedited appeal are included in APP-001, UM-008 and the	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Member Handbook and Provider Manual. Information regarding expedited appeals is included in notice of action letters (14/14 member files with notice of action).	
(7) the Member's right to have benefits continue pending resolution of an appeal or state fair hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.		Full	This information is documented in resolutions letters (KYGA000-11 member partial approval letter and KYGA000-08 denial upheld letter) and is also documented in the Member Handbook. This information is included in adverse determination letters. Adverse appeal decision letters also include this information.	
The notice shall be mailed within ten (10) days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within fourteen (14) days of the date of the action for newly requested services. Denials of Claims that may result in Member financial liability require immediate notification.		Substantial	UM-008 Notice of Action policy includes notice of action within 10 days for previously authorized services. Denial of payment is made on the same day as per policy UM-013, Timeframes for Notice of Action. The timeframe of fourteen days for newly requested services does not appear evident in policies or the Member Handbook. <u>Recommendation for Coventry Cares</u> The plan should include timeframes for notice of action for newly requested	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			services in policies.	
C. 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.		Full	The ability of a member to file an appeal orally or in writing within 30 days of notice of action appears in P/P APP-002 and the Member Handbook. Required written consent for an authorized representative to file an appeal and the ability for a legal guardian to file an appeal are included in APP-002 and in the Member Handbook.	
D. 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. The Contractor shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.		Substantial	As per P/P APP-002, appeal resolution will occur within 30 calendar days. <u>Appeal File Review</u> Of 15 member appeals, 14 included appeal documentation. Of these 14, one was resolved in more than 30 days (Received 11/8, resolution 12/13.) For another member the appeal was resolved within 30 days of receipt of consent for the provider to file the appeal. (Provider appeal received 7/30, consent received 8/13, and resolution 9/10). All 14 appeals were reviewed by a reviewer independent of the initial decision.	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for Coventry Cares</u> The plan should ensure resolution of appeals within 30 calendar days of receipt.</p>	
E. The Contractor shall have a process in place that ensures that an oral or written inquiry from a Member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the Member within ten (10) calendar days. The Contractor shall use its best efforts to assist Members as needed with the written appeal and may continue to process the appeal.		Full	Inclusion of oral or written inquiry regarding an appeal and written appeal to follow an oral appeal are documented in P/P APP-002 and the Member Handbook, and in the oral appeal acknowledgment letter KYGA00017.	
F. Within five working days of receipt of the appeal, the Contractor shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution.		Substantial	<p>As per P/P APP-002 and APP-003, acknowledgement letters are sent within 5 working days, and include expected date of resolution, which is included in the plan's template acknowledgment letter.</p> <p><u>Appeal File Review</u> Of 15 member appeals, 14 included appeal documentation (EPSDT appeal did not). 12/14 member appeal files with appeal documentation included acknowledgement letters within 5 days.</p>	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			<ul style="list-style-type: none"> • One acknowledgment letter was not sent within 5 working days (received 9/10, letter sent 9/19.) • One EPSDT dental appeal file did not include an acknowledgment letter. • As noted above, written consent for one appeal by a provider on a member's behalf was received after 13 days; the acknowledgement letter was sent within 5 working days of receipt of this consent. • There was one expedited member appeal that had a written resolution within one day and therefore did not require written acknowledgement. 9/10 provider appeals included acknowledgement within 5 working days; • 1/10 was sent within 7 days (received 8/29, acknowledgement 9/11). <p><u>Recommendation for Coventry Cares</u> The plan should ensure that the member receives written notice of receipt of appeal within 5 days and includes expected date of resolution.</p>	
G. The Contractor may extend the thirty (30) day timeframe		Full	Information regarding requests for	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
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.			extension that are consistent with the contract is included in P/Ps APP-001, APP-002 and the Member Handbook. None of the reviewed files included documentation of a request for extension by member or by the contractor.	
H. 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.		Full	This information is included in P/P APP-002 and in acknowledgment letters; this language was included in acknowledgment letters in each of the 13 files with an acknowledgement letter.	
I. The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.		Full	This information is included in P/P APP-002 and in acknowledgment letters; this language was included in acknowledgment letters in each of the 13 files with an acknowledgement letter.	
J. 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:		Substantial	The 30 day timeframe for resolution of appeals is included in APP-002 and APP-003, as well as the Member Handbook. <u>Appeal File Review</u> For member appeals, 14/15 files included appeal documentation. 13	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>member appeal files included a written notice of resolution within 30 days. One file included a resolution letter dated more than 30 days from receipt of the grievance (received 11/8, resolution 12/13).</p> <p>8/10 provider files included resolution letters within 30 calendar days. One case was resolved within 30 days, but the written resolution was dated 33 days from receipt (received 11/8, resolved 12/7, written notice 12/12.) One provider file was incomplete and did not include a resolution or written notice.</p> <p><u>Recommendation for Coventry Cares</u> The plan should include resolution letter copies in file documentation.</p>	
(1) the results and reasoning behind the appeal resolution; and		Full	Inclusion of this information in written resolution notices is documented in P/Ps APP-002 and APP-003. This information was included in 14/14 resolution letters in member appeal files, and 9/9 resolution letters in provider appeal files.	
(2) the date it was completed.		Full	Inclusion of this information in written	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			resolution notices is documented in P/Ps APP-002 and APP-003. This information was included in 14/14 resolution letters in member appeal files, and 9/9 resolution letters in provider appeal files.	
K. 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:		Full	Information relevant to appeals not wholly in the member's favor is included in adverse determination letters. 5/10 files included a decision not wholly in the member's favor. All included a written notice of resolution.	
(1) the right to request a state fair hearing and how to do so;		Substantial	Of the 5 member appeals with an adverse (upheld or partial) determination, 4/5 included state fair hearing language. 1/5 files with a decision not entirely in member's favor did not appear to contain fair hearing language in the notice of resolution. <u>Recommendation for Coventry Cares</u> Fair hearing language should be included in resolution letters for decisions not entirely decided in the member's favor.	MCO Response: None
(2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and		Substantial	1/5 files with a decision not entirely in member's favor does not appear to	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>contain fair hearing language in the notice of resolution.</p> <p><u>Recommendation for Coventry Cares</u> The plan should ensure that the notice of resolution for decisions not wholly in the member's favor include fair hearing information as specified.</p>	
(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.		Substantial	<p>1/5 files with a decision not entirely in member's favor does not appear to contain fair hearing language in the notice of resolution.</p> <p><u>Recommendation for Coventry Cares</u> The plan should ensure that the notice of resolution for decisions not wholly in the member's favor include fair hearing information as specified.</p>	MCO Response: None
L. The Contractor shall continue the Member's benefits if all of the following are met:		Full	<p>None of the reviewed files met criteria for continuation of benefits. Description of circumstances for continuation of benefits is included in the Member Handbook.</p>	
(1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair		Non-Compliance	<p>The Member Handbook and P/P APP-002 indicate that if a member wants</p>	MCO Response: Letter number KYGA00008 is being revised by the plan's letter team to



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
hearing within 30 days from the date on the Contractor notice of action;			<p>their benefits to continue during a state hearing they must file within 10 days of notice of action or appeal decision rather than 30 days from the notice of action. This 10 day timeframe is not included in reference to state hearing in the KYGA00008 upheld appeal decision letter.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>include the 10 day timeframe. The letter will be submitted to the Commonwealth for approval.</p> <p>IPRO Comments: No change in review determination.</p>
(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;		Full	This language is included in the Member Handbook; the plan should consider including this continuity of benefits language in policy APP-002. This criterion is currently in policy APP-002 in the definition for action.	
(3) the services were ordered by an authorized service provider;		Full	This language is included in the Member Handbook; the plan should consider including this continuity of benefits	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			language in policy APP-002.	
(4) the time period covered by the original authorization has not expired; and		Full	This language is included in the Member Handbook; the plan should consider including this continuity of benefits language in policy APP-002.	
(5) the Member requests extension of the benefits.		Full	This language is included in the Member Handbook; the plan should consider including this continuity of benefits language in policy APP-002.	
M. The Contractor shall provide benefits until one of the following occurs:				
(1) The Member withdraws the appeal;		Non-Compliance	This language does not appear in the Member Handbook or policy APP-002 or APP-003. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval. IPRO Comments: No change in review determination.
(2) Fourteen (14) days have passed since the date of the		Non-Compliance	This language does not appear in the	MCO Response: Policies APP-002 and APP-



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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;			Member Handbook or policy APP-002 or APP-003. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval. IPRO Comments: No change in review determination.
(3) The Cabinet issues a state fair hearing decision adverse to the Member;		Minimal	This language does not appear explicitly in the Member Handbook or P/Ps APP-002 or APP-003, although there is reference that the member is responsible for paying for services if there is an adverse state fair hearing determination. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO	MCO Response: Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval. IPRO Comments: No change in review determination.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
(4) The time period or service limits of a previously authorized service has expired.		Full	The Member Handbook indicates that benefits will continue if the allowed time for previous authorization has not expired.	
N. 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).		Full	This is included in the Member Handbook and P/P APP-002.	
O. 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.		Substantial	P/P APP-002 indicates that if a decision is in favor of the member, the Appeal Coordinator must update the necessary authorization or notify Health Services to do so. Language regarding payment for services if adverse decision is reversed and prompt and expeditious authorization is not evident in policies. <u>Recommendation for Coventry Cares</u> The MCO should include specific language regarding authorization	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			following reversals of decision in which services were not furnished while appeal was pending into policies.	
24.3 Expedited Resolution of Appeals				
An expedited resolution of an appeal is an expedited review by the Contractor of a Contractor action.				
A. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:		Full	P/P AP-001 describes the expedited appeal process, and the Member Handbook also includes a description of the Expedited (Fast) Appeal process.	
(1) a request from the Member;		Substantial	P/P AP-001 includes member request for expedited appeal, and the process is described in the Member Handbook. There was one expedited appeal among reviewed case files that was a request from a member. P/P APP-001 notes that members must be educated on the right to appeal if they contact Member Services. <u>Recommendation for Coventry Cares</u> In one grievance file (Pernell, Thomas),	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			the member is concerned about denial of injections and is told he could file an appeal, but the member indicates that he is in too much pain to wait for resolution. There is no documentation that expedited appeal was discussed with the member. While expedited appeal may not have been appropriate for this member, the plan could consider addressing how and when expedited appeals should be discussed with members who contact the plan dissatisfied with an adverse action.	
(2) a provider's support of the Member's request;		Full	P/P AP-001 includes provider's support of the Member's request for expedited appeal; this is also referenced in the Member Handbook.	
(3) a provider's request on behalf of the Member; or		Full	P/P AP-001 includes provider's request for expedited appeal on behalf of the member; this is also referenced in the Member Handbook.	
(4) the Contractor's independent determination.		Full	P/P AP-001 includes independent determination of need for expedited appeal and the criteria for such determination.	
The Contractor shall ensure that the expedited review		Full	The process for expedited appeal is	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
process is convenient and efficient for the Member.			outlined in APP-001 and the Member Handbook. The Member Handbook identifies the process for filing an expedited appeal, and indicates that Member Services will assist the member with filing the appeal if the member needs assistance. Interpretation services and TTY-TTD toll free numbers are available for the process as per APP-001.	
B. The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice.		Full	P/P AP-001 includes resolution of expedited appeals within three working days and both reasonable attempt at verbal notification and written notification are included. This is also referenced in the Member Handbook. There was one expedited member appeal that was resolved within one day, with written notification within one day.	
C. The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.		Full	P/P AP-001 and the Member Handbook include required extension language, including notification to the member of the reason for extension request that does not originate with the member. Only one reviewed file was an expedited appeal; there was no extension request.	
E. The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests		Substantial	The Member Handbook indicates that providers are not punished for	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
an expedited resolution or supports a Member's expedited appeal.			requesting or supporting a member's request for expedited appeal. AAP-001 does not address this issue. Punitive action against a member is not referenced in the Member Handbook or APP-001. <u>Recommendation for Coventry Cares</u> The plan should include assurance that punitive action will not be taken against a member who requests an expedited appeal in the Member Handbook and policy.	
F. The Contractor shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the Member or service provider on behalf of the Member.		Full	Both P/P AP-001 and the Member Handbook note that a request for expedited appeal can be from the member or provider and can be an oral or written request. The one expedited appeal that was reviewed resulted in an overturn of denial within one day.	
G. The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.		Full	P/P APP-001 states that the appeal will be completed in 3 days; limited time available is not explicitly addressed. P/P APP-001 and the Member Handbook indicate that a decision will be made within 3 working days and that an extension of 14 days may be requested	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			by the member to provide more information.	
H. 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		Full	P/P AP-001 states that a denied expedited appeal will be transferred to a standard appeal timeframe, starting from receipt of the appeal request. The Member Handbook indicates that if an expedited appeal is denied it will be treated as a regular appeal beginning with date of receipt.	
(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.		Substantial	P/P AP-001 documents that the Appeal Coordinator will call the member if an appeal does not meet expedited criteria and is converted to a standard appeal, and that written notice of denial of expedited appeal will be sent within 2 calendar days. The Member Handbook indicates that the plan will call or write to the member if the regular appeal process will be followed. There were no case files in the sample that were converted from expedited to standard appeals. <u>Recommendation for Coventry</u>	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Cares</p> <p>The plan should amend the Member Handbook information regarding a denied request for expedited appeal to be consistent with policy and the contract requirements.</p>	
I. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.		Full	As per P/P AP-001, oral requests for expedited appeal will be documented and maintained in the case file. Such documentation was included in the single expedited appeal in the sample of reviewed cases. In the expedited appeal folder, the plan provided a sample of KY GA00017 oral appeal acknowledgement letter, which appears to be relevant to standard appeals, as it references a 30 day resolution time frame and closing an appeal if a signed form is not received by a certain date. This would not be consistent with the plan's process for expedited appeal, which includes oral requests.	
24.4 State Hearings for Members				
A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, within thirty (30) days of receiving notice of the Action or within thirty (30) days of the final decision by the		Full	Requesting a State Fair Hearing is outlined in the Member Handbook, P/P APP-002, P/P APP-001, and in resolution letters to members when denials are	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Contractor.			upheld.	
All documents supporting the Contractor's Action must be received by the Department no later than five (5) days from the date the Contractor receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. The Department will provide the Member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.		Full	The plan provided a State Fair Hearing Procedure for CoventryCares of Kentucky document revision date 2/2012 that includes a process for forwarding documents to the Commonwealth contact person within 5 days of receipt of notice of fair hearing. P/P APP-002 indicates that members are entitled to access to and copies of all documents relevant to an appeal upon request. Upheld appeal resolution letters also indicate that members can request a free copy of appeal documentation.	
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	This provision is included in the State Fair Hearing Procedure for CoventryCares of Kentucky document as well as the State Fair Hearing Process Summary updated 1/2013. There were no examples of state hearings in reviewed documents.	
27.8 Provider Grievances and Appeals				
The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or		Minimal	P/P APP-003 addresses provider grievances and appeals. Coventry also identifies a category called "claims	MCO Response: CoventryCares of Kentucky has made many improvements to the Grievance System in 2013. Improvements



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>an appeal with the Contractor. 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. A Provider may not file a grievance or an appeal on behalf of a Member without written designation by the Member as the Member's representative. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues.</p>			<p>review", which is not a grievance or appeal but a process for claims issues that providers are encouraged to pursue before filing grievances or appeals. These are documented as an "inquiry" in Navigator. The plan indicated onsite that some grievances and appeals may actually be inquiries, although identified as grievances or appeals. A provider's right to file a grievance or appeal is noted in the Provider Manual and Provider grievances are described in member grievance policy APP-004, and examples include perceived lack of helpfulness of Customer Service representatives and timeliness of claim payment. P/P APP-003 defines a grievance as an expression of dissatisfaction with policies, procedures or any aspect of health plan functions.</p> <p><u>Grievance File Review</u> While some provider grievances were on behalf of members and some were claims-related, it appeared that there was some confusion between provider grievances and inquiries among the provider grievance files. In one file the provider was calling to complain about</p>	<p>include:</p> <ol style="list-style-type: none"> 1) Implementation of Quality Check tool for Grievances. Management performs the Quality Check weekly. Metrics are submitted to senior management to review and identify corrective action, as needed. 2) A team member has been assigned to be fully responsible for handling Grievances. Remaining team members are full trained in handling Grievances for back-up and during the principal employee's leave. This individual dedicates their time to tracking grievances and ensuring timeliness, compliance, and quality. 3) A Tracking Log has been created to track issues opened as complaints but not worked as complaints. The Tracking Log assists the Grievance and Appeals manager in identifying issues related to staff training for the Grievance and Appeals team as well as the call center staff. Issues are reported to the appropriate department to management to reinforce appropriate handling of issues.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Provider Relations not returning phone calls; a sticky note on file indicates that this was not handled as a complaint. Another case, whose call about a member may not have been a complaint, included a notation that providers do not have a grievance option. The documentation in the file for another member was not clear, although a sticky note indicates that it is not a complaint.</p> <p>As per P/P AAP-003, grievances are acknowledged within five working days for pre-service issues. Appeals are to be acknowledged within 5 working days as per APP-003 and resolved within 30 calendar days with written notice provided. APP-003 does not reference resolution of provider grievances within 30 days, although the Provider Manual does, and APP-004 appears to reference resolution of both member and provider grievances within 30 days. As noted above, 9/10 provider appeals received acknowledgement within 5 days. Only 3/15 provider grievances received an acknowledgement letter, including 2/3 that were member grievances, and one</p>	<p>4) The person responsible for grievances will use daily grievance reports to monitor inquiries coded as grievances, and issues that require action. If any complaint is closed that does not contain all of the necessary components, the case will be reviewed and either re-coded correctly, or will be re-opened as a complaint and acknowledged. This report will be viewed by the Manager and Coordinator to make sure nothing is missed. A weekly report will also be sent to the grievance coordinator so they can double check the closures.</p> <p>IPRO Comments: No change in review determination.</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>other provider grievance regarding a denial and lack of a return call from Provider Relations.</p> <p>6/15 files in the provider grievance sample included documentation that they were resolved in 30 days.</p> <ul style="list-style-type: none"> • 8/15 grievance files did not include a clear date of resolution. • 1/15 provider complaints was resolved in 34 days. • 9/10 provider appeals were documented as resolved within 30 days. <p>There is no reference to fourteen day extension policy in APP-003, although it appears in the Provider Manual for grievances and in member appeal policy APP-002. A sample extension letter for provider appeals KYGA00013 informs the provider that more time is needed for the appeal, but does not request the extension from the provider. P/P APP-003 includes written authorization for appeals to be filed on behalf of members.</p> <p>Written consent for filing appeals for</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>members is included in P/Ps APP-002 and APP-003 and is in the Provider Manual. All provider appeals filed on behalf of a member included consent in the files.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	
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 enter into a contract.		Full	Providers are informed of the provider and member grievance system in the Provider Manual. Coordination with subcontractors for member grievances and appeals is documented in P/P APP-005. The General Record Retention under Kentucky Law chart updated 2013 indicates that service providers and subcontractors are informed about the grievance system at the time they enter into contract. Policy APP-004 notes that	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 plan investigates and resolves grievances regarding services provided by vendors.	
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.		Full	The MCO provided a General Record Retention under Kentucky Law chart updated 2013 that indicates that grievance and appeals files are retained for 10 years following decision in a secure and designated area, and will be accessible to the Department or designee upon request.	
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.		Full	This is included in the General Record Retention under Kentucky Law chart. P/Ps APP-001, App-002 and APP-004 also include required elements for files.	
Documentation regarding the grievance shall be made available to the Member, if requested.		Full	This is included in the General Record Retention under Kentucky Law chart, and the process for requests is outlined in policy HIPAA-006.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	54	17	8	3
Total Points	162	34	8	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		204/82=2.49		

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 |



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings

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

Process for quality oversight of grievance processing

Evidence of quality oversight and follow-up for grievance processing

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 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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				
The Contractor shall have programs and processes in place to address the preventive and chronic 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	P/P CM-022 describes the process to identify, assess and monitor members' chronic disease, urgent health needs and modifiable risk factors, and the process for health risk assessment is further described in P/P CM-021. The process for identification and effective management of individuals with special health care needs, including Aged, Blind and Disabled populations, foster care and adoptive services and physical and developmental disabilities, is described in P/P CM-017, and complex case management is described in P/P CM-017. Case and disease management programs are also described in the Member Handbook.	
The Contractor shall conduct initial health screening assessment 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. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.		Minimal	<p>P/P CM-022 documents health screening assessment for new members within 90 days and within 30 days of enrollment for pregnant members. Assessment tools were provided that provide evidence of assessment of members' needs (Medicaid Regulatory Assessment, Good Health Profiles).</p> <p><u>HRA File Review</u> The plan provided only 3/50 files for review, so it could not be ascertained how frequently timely health screening was conducted. Of the 3 files provided with completed Health Risk Assessments (HRAs),</p>	<p>MCO Response: CoventryCares of Kentucky handles the Medicaid Regulatory assessment in-house and not as a portion of the Health Risk Assessment (HRA) contracted to NRC. NRC Good Health Profile is a screening tool that assists in stratifying a Member's risks and appropriateness for case management. The Medicaid Regulatory assessment is completed by a CoventryCares of Kentucky case manager within 30 days of member enrollment into case management.</p> <p>The NRC Good Health Profile assessment</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>one did not provide a clear date of completion so it is unclear when it was completed. The others were completed timely.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>completion date is listed in the enclosed spreadsheet for member as noted in your findings.</p> <p>Through the EQRO response process, CoventryCares of Kentucky identified the file extract sent to NRC was flawed. Members, who became eligible after the extract was sent on the 8th of each month, were not sent to NRC. The extract has been corrected.</p> <p>CoventryCares of Kentucky has asked NRC to review all the members affected by the erroneous file extract and to perform and HRA if the (member is still Medicaid eligible and a Coventry member.</p> <p>IPRO Comments: No change in review determination.</p>
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire.		Minimal	P/P CM-022 includes making reasonable efforts to contact members. As per policy CM-021, the plan's contracted vendor conducts three calls at three different times on three different days; if still unable to reach the member, a letter is sent to the member to call the vendor on a toll free number. The HRA will be completed on the phone or mailed if requested. A detailed process for contacts is outlined in the document National Research Corporation Health Risk Assessment Data Collection	<p>MCO Response: As mentioned above, the 47/50 files without contact activity were the result of a flawed identification process. Members who are correctly identified and transmitted to NRC will have contact activity that is demonstrated in the enclosed spreadsheet (NRC Member Contact Activity).</p> <p>IPRO Comments: No change in review determination.</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

<p align="center">Health Risk Assessment <i>(See Final Page for Suggested Evidence)</i></p>				
<p align="center">State Contract Requirements (Federal Regulation: Not Applicable)</p>	<p align="center">Prior Results & Follow-Up</p>	<p align="center">Review Determination</p>	<p align="center">Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</p>	<p align="center">Health Plan's and DMS' Responses and Plan of Action</p>
			<p>Policy.</p> <p>Although by policy completed HRAs are given to the plan for review, only 3/50 requested files were provided to the IPRO reviewer. For one of the files, there is documentation of multiple attempts at calls and letters between 11/29/12 and 1/14/13 until the HRA was completed on an unclear date. The other two files were completed timely. It could not be ascertained how many attempts were made for the 47 files not provided for review.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	
<p>Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.</p>		<p>Substantial</p>	<p>P/P CM-022 indicates that this information should be included in Health Risk Assessments, and the tools used to collect HRA information contain these elements, including the Medicaid Regulatory Assessment. Of the three completed HRAs submitted, 2/3 included demographic information. 3/3 files included current</p>	<p>MCO Response: None</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>health and behavioral status to determine need for care management, disease management, behavioral or other health services.</p> <p><u>Recommendation for Coventry Cares</u> HRA files should include demographic information.</p>	
The Contractor shall use appropriate healthcare professionals in the assessment process.		Full	P/P CM-022 indicates that appropriate health care professionals will be used in the assessment process, and P/P CM-021 indicates that the Health Services Director will report clinical information to appropriate management staff. Per policy CM-004, the HRA is used to identify members for complex case management, and to identify members with special needs as per P/P CM-017 for case management.	
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.		Substantial	<p>As per P/P CM-022, members are encouraged to contact their PCP and schedule a PCP visit. Assisting the member with an appointment is not specifically referenced. Of the 3 completed HRAs submitted for review, 0/3 required assistance with a PCP appointment, as they had either already had an appointment or had one scheduled.</p> <p><u>Recommendation for Coventry Cares</u> The MCO should ensure that members are</p>	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Health Risk Assessment <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			offered assistance by policy if unable to schedule on their own.	
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	Coventry Cares provided copies of quarterly reports from 2012 and 1/30/13 that included number of new assessments, completed assessment, not completed after reasonable effort and refusals. In addition, summary response rates for March through December 2012 were provided.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	3	2	2	0
Total Points	9	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		15/7=2.14		

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

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



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan’s and DMS’ Responses and Plan of Action
27.2 Provider Credentialing and Recredentialing				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department’s current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,		Full	P/P CP – 014, Provider Enrollment addresses this requirement. P/P CP – 003, Recredentialing also addresses this requirement. Credentials Verification Center (CVC) Policy and Procedure Manual addresses this requirement.	
defining the scope of providers covered,		Full	P/P CP - 014 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
the criteria and the primary source verification of information used to meet the criteria,		Full	P/P CP -001, Provider Types and Requirements addresses this requirement.	
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.		Full	P/P CP – 005, Credentials Committee addresses this requirement. CVC Policy and Procedures also addresses this requirement.	
The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.		Full	P/P CP – 009 Provider Resolution addresses this requirement. CVC Policy and Procedure Provider Application also addresses this requirement.	
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners,		Full	P/P CP – 005 Credentials Committee addresses this requirement. CVC Policy and Procedures addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.				
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.		Full	P/P CP – 014, Provider Enrollment addresses this requirement. P/P CP – 001, Provider Types Requirements Rights also addresses this requirement.	
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	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
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	CVC Policy and Procedures addresses this requirement.	
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such		Full	P/P CP- 014 addresses this requirement. CVC Policy and Procedures addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
additional information as may be specified by the Department.				
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
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	P/P CP - 014 addresses this requirement. P/P CP- 003, Recredentialing also addresses this requirement.	
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;		Full	P/P CP - 005 addresses this requirement. CVC Policy and Procedures also addresses this requirement.	
C. A review of the credentialing policies and procedures by the formal body;		Full	P/P CP - 005 addresses this requirement.	
D. A credentialing committee which makes recommendations regarding credentialing;		Full	P/P CP - 005 addresses this requirement.	
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;		Full	CVC Policy and Procedures addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
F. Written procedures for the termination or suspension of Providers; and		Full	P/P CP – 013, Credentialing Denial and Termination addresses this requirement. CVC Policy and Procedures addresses this requirement.	
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	P/P CP - 013 addresses this requirement.	
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:		Substantial	<p>P/P CP - 001 addresses this requirement. CVC Policy and Procedures also addresses this requirement.</p> <p>During the onsite review, IPRO reviewed 10 PCP credentialing files and 10 Specialist credentialing files with the following results:</p> <p><u>PCP Files:</u></p> <p>1 PCP – Unable to determine hospital privileges.</p> <p>2 PCPs – No evidence of hospital affiliations.</p> <p>1 PCP – Out of state License (no license in KY).</p> <p><u>Specialist Files:</u></p> <p>1 Specialist – Not a specialist – an Internal Medicine physician with no secondary specialty.</p> <p>1 Specialist – unable to determine board certification.</p>	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>1 Specialist – out of state license (no license in KY).</p> <p>Overall, although information was presented, the files were inconsistently organized.</p> <p>Coventry Cares advised during the onsite review that the Credentialing Committee will be located locally in Kentucky beginning April 2013.</p> <p><u>Recommendation for Coventry Cares</u> Files provided should include complete information. The MCO should include a provider profile in the physician's chart. A provider profile aids the MCO during the recertification period regarding over/under utilization and grievances from members.</p>	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.		Full	CVC Policy and Procedures addresses this requirement.	
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;		Full	P/P CP – 014, Provider Enrollment addresses this requirement. CVC Policy and Procedures addresses this requirement.	
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	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
D. Board certification if the practitioner states on the application that the practitioner is board certified in a		Full	P/P CP - 014 addresses this requirement. P/P CP - 003 also addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
specialty;				
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	P/P CP - 005 addresses this requirement. CVC Policy and Procedures also addresses this requirement.	
F. Previous five (5) years work history;		Full	P/P CP - 005 addresses this requirement.	
G. Professional liability claims history;		Full	P/P CP - 005 addresses this requirement.	
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	CVC Policy and Procedures addresses this requirement.	
I. Current, adequate malpractice insurance, as verified through attestation;		Full	P/P CP - 013 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
K. Documentation of curtailment or suspension of medical staff privileges;		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;		Full	P/P CP - 001 addresses this requirement.	
M. Documentation of censure by the State or County		Full	P/P CP - 001 addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
professional association; and				
N. Most recent information available from the National Practitioner Data Bank.		Full	P/P CP - 014 addresses this requirement.	
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	Credentialing Application addresses this requirement.	
B. Lack of present illegal drug use;		Full	Credentialing Application addresses this requirement.	
C. History of loss of license and felony convictions;		Full	Credentialing Application addresses this requirement.	
D. History of loss or limitation of privileges or disciplinary activity;		Full	Credentialing Application addresses this requirement.	
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and		Full	Credentialing Application addresses this requirement.	
F. Applicant attests to correctness and completeness of the application		Full	Credentialing Application addresses this requirement.	
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	CVC Policy and Procedures addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and		Full	P/P CP - 001 addresses this requirement.	
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.		Full	CVC Policy and Procedures addresses this requirement.	
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and/or as required by law.		Full	P/P PR – 009, Provider Site Review and Physical Access policy - readiness review addresses this requirement.	
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.		Full	P/P PR - 009 addresses this requirement.	
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	P/P PR - 009 addresses this requirement.	
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:		Full	P/P CP - 003 addresses this requirement.	
A. A current license to practice;		Full	P/P CP - 014 addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
C. A valid DEA, if applicable;		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recertified;		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
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	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
F. A current signed attestation statement by the applicant regarding:		Full	Credentialing Application addresses this requirement.	
1. The ability to perform the essential functions of the position, with or without accommodation;		Full	Credentialing Application addresses this requirement.	
2. The lack of current illegal drug use;		Full	Credentialing Application addresses this requirement.	
3. A history of loss, limitation of privileges or any disciplinary action; and		Full	Credentialing Application addresses this requirement.	
4. Current malpractice insurance.		Full	Credentialing Application addresses this requirement.	
There shall be evidence that before making a recertification decision, the Contractor has verified information about sanctions or limitations on		Full	CVC Policy and Procedures addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
practitioner from :				
A. The national practitioner data bank;		Full	CVC Policy and Procedures addresses this requirement.	
B. Medicare and Medicaid;		Full	P/P CP - 001 addresses this requirement. CVC Policy and Procedures addresses this requirement.	
C. State boards of practice, as applicable; and		Full	P/P CP - 001 addresses this requirement.	
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.		Full	CVC Policy and Procedures addresses this requirement.	
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	CVC Policy and Procedures addresses this requirement.	
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.		Full	P/P CP – 004, Ongoing Monitoring addresses this requirement.	
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,		Full	P/P CP – 004 addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.				
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	P/P CP – 004 addresses this requirement.	
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	P/P PR – 009, Provider Site Review and Physical Access policy addresses this requirement.	
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	P/P CP – 013, Credentialing Denial and Termination addresses this requirement.	
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	P/P CP – 014, Provider Enrollment addresses this requirement.	
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Types.htm		Full	P/P CP – 014 addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
28.1 Network Providers to be Enrolled				
<p>The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. 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, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, 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</p>		<p>Full</p>	<p>P/P PR -012, Provider Recruitment addresses this requirement. P/P ND – 001, Provider Recruitment, Network Shortage Policy addresses this requirement.</p>	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members.</p> <p>Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.</p>				
<p>Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the OSCAR file provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.</p>		Full	CVC Policy and Procedures addresses this requirement.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.		Full	P/P CP-006, Provider Discrimination and Excluded Providers addresses this requirement.	
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	P/P CP-013 addresses this requirement.	
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.		Full	P/P ND – 003, Selection and Retention of Network addresses this requirement.	
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a format specified by the Department report all out-of-network utilization by Members.		Full	P/P ND – 001, Provider Recruitment, Network Shortage Policy addresses this requirement.	
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network		Full	P/P ND – 003, Selection and Retention of	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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 in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.</p>			<p>Network addresses this requirement.</p>	
<p>28.4 Enrolling Current Medicaid Providers</p>				



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent. The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.</p>		Full	CVC Policy and Procedures addresses this requirement.	
<p>28.5 Enrolling New Providers and Providers not Participating in Medicaid</p>				
<p>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.</p>		Full	P/P CP -014 addresses this requirement.	
<p>28.6 Termination of Network Providers or Subcontractors</p>				



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Any Provider or Subcontractor who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation.		Full	P/P CP -002, Credentialing Review Elements addresses this requirement.	
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 Department will notify the Contractor of voluntary terminations within five business days via email.		NA	DMS responsibility.	
The Contractor shall notify the Department of suspension, termination, and exclusion from Contractor's network taken against a Provider within three business days via email. The Contractor shall notify the Department of voluntary terminations within five business days via email. The Contractor will provide all terminations monthly, via the Provider Termination Report as referenced in Appendix K. The Contractor shall terminate the Provider effective the same date as the Medicaid program termination.		Full	P/P CP -013 addresses this requirement. CVC Policy and Procedures addresses this requirement.	



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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	79	1	0	0
Total Points	237	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		239/80=2.99		

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



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

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 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	<p>Primary Care Provider Responsibilities addressed in Provider Manual.</p> <p>The MCO performs an annual access and availability surveys of PCPs and Specialists. The final reports are sent to the State.</p> <p>Secret Shopper program targeting high volume practitioners is scheduled for March 2013.</p>	
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	<p>Appeal process addressed in Provider Manual and the Member Handbook.</p> <p>P/P APP-002, Appeals Members addresses this requirement.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;		Full	Maintaining continuity of the member's health care is addressed in the Provider Manual.	
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;		Full	Referrals for specialty care providers both in and out of network are addressed in the Provider Manual.	
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;		Full	Maintaining the medical record is addressed in the Provider Manual.	
D. Discussing Advance Medical Directives with all Members as appropriate;		Full	Advanced Medical Directives are addressed in the Provider Manual. P/P RR—001 – Advanced Directives addresses all requirements.	
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	EPSDT is addressed in the Provider Manual. P/P UM-046, EPSDT addresses all requirements.	
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and		Full	Complete and accurate medical record documentation is addressed in the Provider Manual.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers		Full	Referral to behavioral health providers is addressed in the Provider Manual.	
Maintaining formalized relationships with other PCPs to		Full	After hours care is addressed in the Provider	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.			Manual. During the Onsite Coventry advised that they are working to expand their participation with Urgent Care Centers to fill the after-hours gaps in care.	
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	P/P PR – 002, Provider Accessibility and Availability addresses all the requirements. After hours care is addressed in the Provider Manual and P/P PR – 002, Provider Accessibility and Availability.	
(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	Addressed in P/P PR – 002.	
(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	Addressed in P/P PR – 002.	
B. Unacceptable				
(1) Office phone is only answered during office hours;		Full	Addressed in P/P PR – 002.	
(2) Office phone is answered after hours by a recording		Full	Addressed in P/P PR – 002.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
that tells Members to leave a message;				
(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	Addressed in P/P PR – 002.	
(4) Returning after-hours calls outside of thirty (30) minutes.		Full	Addressed in P/P PR – 002.	
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all Covered Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of Medically Necessary services.		Full	Addressed in P/P PR – 002.	
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.		Full	Addressed in P/P PR – 002 and P/P ND -002, Availability of Practitioners.	
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	P/P UM – 019, Emergency and Post Stabilization Services addresses all requirements.	
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		Full	Addressed in P/P PR – 002 and P/P ND -002.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(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.				
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. Specialists shall be commensurate with the subpopulations designated by the Department, and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age.		Minimal	<p>Addressed in P/Ps PR 006, Accessing Appointment Availability and PR – 002, Provider Accessibility and Availability.</p> <p>Evidence of monitoring provider compliance with hours of operation, including after-hours availability was not available. Geo Access reports were provided and are discussed below.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>MCO Response: Coventry Cares has instituted a "Secret Shopper" program, overseen by our regional Vice President of Quality Improvement. Among other things, the "Secret Shopper" program randomly checks on providers to ensure minimum accessibility requirements are met. The first Secret Shopper cycle was completed in-house. Based on the results, the plan has contracted with CareCall to perform a follow-up access and availability survey before the close of third quarter 2013.</p> <p>IPRO Comments: No change in review determination.</p>
C. 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	Addressed in P/P UM – 019, Emergency and Post Stabilization Services.	
D. Hospital care for which transport time shall not exceed thirty (30) minutes, except in non-urban areas where		Full	Addressed in P/Ps PR – 002 and P/P ND -002.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
access time may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) minutes.				
E. General dental services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.		Full	Addressed in P/Ps PR – 002 and P/P ND -002.	
F. General vision, laboratory and radiology services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.		Full	Addressed in P/Ps PR – 002 and P/P ND -002.	
G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.		Full	Addressed in P/Ps PR – 002 and P/P ND -002.	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;		Full	Addressed in P/P PR-002, Provider Accessibility and Availability.	
B. FQHCs and rural health clinics;		Full	Addressed in P/P PR-002, Provider Accessibility and Availability.	
C. The Kentucky Commission for Children with Special		Full	Addressed in P/P PR-002, Provider Accessibility	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
Health Care Needs; and			and Availability.	
D. Community Mental Health Centers		Full	Addressed in P/P PR-002, Provider Accessibility and Availability.	
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.		Non-Compliance	<p>Documents provided do not include the requirement for advising the Department if agreements are not established with the providers listed above.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>MCO Response: Coventry Cares of Kentucky currently has contracts with all teaching hospitals and FQHCs located in Kentucky and with the Kentucky Commission for Children with Special Health Care Needs. In addition, Coventry Cares of Kentucky has a contractual relationship with all Community Mental Health Centers through its subcontractor, MHNet. Also, all RHCs have been recruited and the majority are participating with Coventry Cares of Kentucky. Coventry Cares will revise its Policies and Procedures to include provisions for advising the Department if at any time any of these providers are not contracted.</p> <p>Policy ND-001 has been updated to state that the Department will be notified if agreements are not established for the four provider types listed above.</p> <p>I PRO Comments: No change in review determination.</p>
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following provisions:				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.		Full	Addressed in P/P PR -012, Provider Recruitment V3 and provider agreements.	
B. Provide reimbursement at rates commensurate with those provided under Medicare.		Full	Documentation provided does not address this requirement. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Coventry Cares and the Dept. for Public Health executed an agreement in 2011 that mandated the rates for the Department for Public Health at the 2011 Kentucky Medicaid rates, which were established to mirror Medicare. IPRO Comments: Review determination changed to Full.
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.		Non-Compliance	P/Ps PR-002 and ND-002 do not address this requirement. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Policy and Procedures will be modified to note that charitable providers are eligible for inclusion in the Coventry Cares of KY Network if credentialing standards are met. IPRO Comments: No change in review determination.
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		Substantial	Policies/procedures provided do not address this requirement. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract	MCO Response: Policy ND-001 has been updated to reflect this requirement. However, CoventryCares has met this requirement by providing regular provider files to the Department for Medicaid Services which the Department



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>			<p>(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>reviews for access requirements. Additionally, the Department reviewed the network during readiness review in October and November 2011 and again in December 2012. CoventryCares has met this requirement by providing regular provider files to the Department for Medicaid Services which the Department reviews for access requirements</p> <p>Coventry Cares of Kentucky recruited key providers immediately after being awarded the Medicaid Managed Care contract. Contracts were pursued based on priorities set through review of previous Medicaid utilization to identify and target providers with high utilization for initial recruitment. CoventryCares has contracted with all but nine general acute care hospitals in Kentucky and the major out of state hospitals that have experienced significant KY Medicaid utilization (Vanderbilt, Cabell-Huntington, University of Cincinnati, The Christ Hospital, and Deaconess Healthcare). Additionally, CoventryCares has contracted with 100% of the FQHCs. CoventryCares of Kentucky has not experienced out of network utilization that we were not able to address and assure member access when appropriate.</p> <p>Finally, Coventry Cares of Kentucky provides regular GeoAccess reports to the Commonwealth to track the availability of all services in the network, in compliance with established Commonwealth of Kentucky guidelines on provider</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
				accessibility, by specialty. IPRO Comments: Review determination changed to Substantial. Compliance demonstrated in GEO Access reports. P/P updated.
28.8 Program Mapping				
The Contractor shall initially submit a series of maps and charts in a format prescribed by the Department that describes the Contractor's Provider Network, as set forth below. The use of computer-generated maps is preferred. Maps shall include geographic detail including highways, major streets and the boundaries of the Contractor's network. In addition to the maps and charts, the Contractor shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care.		Full	Addressed in P/Ps PR - 002 and PR - 012.	
Maps shall include the location of all categories of Providers or provider sites as follows:				
A. Primary Care Providers (designated by a "P")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
B. Primary Care Centers, non FQHC and RHC (designated by a "C")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
C. Dentists (designated by a "D")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
D. Other Specialty Providers (designated by a "S")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
E. Non-Physician Providers - including nurse		Full	Coventry Cares provided GEO Access Reports	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A")			demonstrating compliance.	
F. Hospitals (designated by a "H")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
G. After hours Urgent Care Centers (designated by a "U")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
H. Local health departments (designated by a "L")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
J. Pharmacies (designated by a "X")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
K. Family Planning Clinics (designated by an "Z")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
L. Significant traditional Providers (designated by an "**")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
M. Maternity Care Physicians (designated by a "o")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
N. Vision Providers (designated by a "V")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
O. Community Mental Health Centers (designated by a "M")		Full	Coventry Cares provided GEO Access Reports demonstrating compliance.	
The Contractor shall update these maps to reflect changes in the Contractor's Network on an annual basis,		Substantial	P/P PR – 002 provided, however this policy does not address updates.	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
or upon request by the Department.			Recommendation for Coventry Cares It is recommended that the MCO update the policy to include this requirement.	
28.9 Expansion and/or Changes in the Network				
If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify the Department of this situation and 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	P/P PR – 007, Provider Recruitment, Network Shortage Policy addresses this requirement.	
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	P/P PR – 007 and P/P PR - 012 address this requirement.	
30.1 Medicaid Covered Services				
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered		Full	The Member Handbook addresses all the requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.				
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	P/P UM-004, Continuity Coordination of Care addresses all the requirements.	
After the Execution Date, 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 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		NA	DMS responsibility.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.		NA	Coventry Cares stated that this is not applicable.	
If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly 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	P/P UM-037, Family Planning Services and Treatment for Sexually Transmitted diseases addresses this requirement.	
The Contractor shall not prohibit or restrict a Provider from advising a beneficiary 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	Provider Manual addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	Provider Manual addresses this requirement.	
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	P/P UM-039, Prior Authorization Review addresses this requirement.	
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	The Member Handbook and P/P UM-019, Emergency and Post Stabilization Services address this requirement. P/P PR-006, Assessing Appointment Availability addresses emergency care.	
32.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in accordance with 42 CFR 431.52 and 907 KAR 1:084. These		Full	P/P UM – 019, Emergency and Post Stabilization Services addresses all requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
regulations require that the Commonwealth, including Department and its Contractor, cover not only Medically Necessary services due to a medical emergency, but also out-of-state medical services if medical services are needed and the member's health would be endangered if he/she were required to travel to his/her state of residence.				
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.		Full	P/P UM – 019, Emergency and Post Stabilization Services addresses all the requirements. P/P CSO-002, Claims Processing also addresses this requirement.	
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.		Full	Member Handbook and P/P UM-020, Direct Access Services address all the requirements.	
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				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;		Full	Member Handbook and P/P UM-020 Direct Access Services, address all the requirements.	
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;		Substantial	Member Handbook addresses this requirement. <u>Recommendation for Coventry Cares</u> It is recommended that oral surgery services and evaluations by orthodontists and prosthodontists be added to P/P UM-020.	MCO Response: None
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	
D. Maternity care for Members under 18 years of age;		Full	Member Handbook and P/P UM-020 Direct Access Services address maternity care.	
E. Immunizations to Members under 21 years of age;		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	
F. Sexually transmitted disease screening, evaluation and treatment;		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	
G. Tuberculosis screening, evaluation and treatment;		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	
I. Chiropractic services; and		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
J. Women's health specialists.		Full	Member Handbook and P/P UM-020 Direct Access Services address this requirement.	
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	Member Handbook, P/P UM-020 and P/P UM-037, Family Planning Services and Treatment for Sexually Transmitted Diseases address this requirement.	
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.		Full	P/P HIPAA-010, Notice of Privacy addresses confidentiality. The Member Handbook addresses confidentiality for Family Planning Services.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	71	3	1	2
Total Points	213	6	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		220/77=2.85		

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
- 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

Provider Access and Availability Reports

Provider program capacity/program mapping reports including geo access, in required format for:

- Primary care
- Specialty care
- Emergency care



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

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 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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	UM Program 2011-2012 addresses this requirement.	
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	UM Program 2011-2012 addresses this requirement.	
The description shall include the scope of the program;		Full	UM Program 2011-2012 addresses this requirement.	
the processes and information sources used to determine service coverage;		Full	UM Program 2011-2012 addresses this requirement.	
clinical necessity, appropriateness and effectiveness;		Full	UM Program 2011-2012 addresses this requirement.	
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;		Substantial	UM Program 2011-2012 addresses most of the requirements. P/P UM – 051, Discharge Planning and P/P UM-004, Continuity Coordination of Care address this requirement. <u>Recommendation for Coventry Cares</u> It is recommended that triage decisions be addressed in the UM Program.	MCO Response: None
processes to review, approve, and deny services as needed.		Full	UM Program 2011-2012 addresses this requirement. P/P UM-039, Prior Authorization	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			Review addresses this requirement.	
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.		Full	UM Program 2011-2012 addresses this requirement. <u>UM File Review</u> 20 UM Files (medical necessity decisions) and 5 EPSDT Files were reviewed with the following results: the majority of the files were for physical therapy services which were partially denied. All documents were in order. UM and Medical Director comments/findings clearly documented. All Notice of Action letters sent timely with accurate verbiage pertaining to the denial.	
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	UM Program 2011-2012 addresses this requirement.	
The Contractor shall adopt national recognized standards and criteria which shall be approved by the Department.		Full	UM Program 2011-2012 addresses this requirement. P/P UM-002, Clinical Review criteria addresses this requirement. The MCO provided the QM UM Minutes to address this requirement. In addition, InterQual Guidelines Revisions Summary was provided as evidence for this requirement.	
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the		Full	UM Program 2011-2012 Medical Necessity Definition addresses this requirement. P/Ps UM	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
review and adoption of Medical Necessity criteria.			<p>– 012, Use of Board Certified Consultants in the UM Decision Making Process and UM-002, Clinical Review criteria address this requirement.</p> <p>The MCO also provided QM UM Minutes to address this requirement.</p> <p>InterQual Guidelines Revisions Summary was provided as evidence.</p>	
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.		Full	<p>UM Program 2011-2012 Inter Rater Reliability addresses this requirement.</p> <p>P/P UM – 018, InterQual Inter Rater Reliability Testing Policy addresses this requirement.</p> <p>The MCO advised that for the Health Services Nursing staff, the McKesson IRR testing is conducted annually, during the 4th quarter for the following facilities:</p> <ul style="list-style-type: none"> • Home Care • Sub acute and SNF • Acute • DME • Imaging • Long Term Acute Care • Overview IRR Analysis 	
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending		Full	<p>UM Program 2011-2012 Medical Review Determinations addresses this requirement.</p> <p>UM Program 2011-2012 Clinical Review Guidelines addresses this requirement.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 or other health care provider as appropriate.			P/P UM – 002, Clinical Review criteria addresses this requirement.	
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	UM Program 2011-2012 Oversight and UM Program 2011 – 2012 Medical Review Determinations address this requirement.	
The reason for the denial shall be cited.		Full	UM Program 2011-2012 Notice of Denials for Service addresses this requirement. P/P UM – 008, Notice of Action Policy addresses this requirement.	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.		Full	UM Program 2011-2012 Medical Review addresses this requirement. P/P UM – 012, Use of Board Certified Consultants addresses the requirements.	
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.		Full	UM Program 2011-2012 addresses the requirements.	
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.		Full	Prior Authorization List Submission to Commonwealth for approval addresses all requirements. Coventry Cares submitted as evidence the following documentation to the Department on 4/14/12. <i>As required by Section 20.6 of Coventry's contract with the Commonwealth,</i>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			<i>we are submitting revisions to the CoventryCares of Kentucky prior authorization list for review. There are a few additions to the PA list but this revision primarily removes PA requirements. A high level summary of the changes follows.</i>	
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	The UM Description addresses this requirement. P/P UM – 021, Delegated Utilization Management addresses all requirements. Coventry submitted the following delegated contracts for review: <ul style="list-style-type: none"> • ASH Contract • Avesis Contract • MHNNet Contract. 	
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 two working days of providing notification of a decision if the decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.		Full	P/P UM-008, Notice of Action and P/P UM-013, Time Frames for Notice of Action address this requirement. UM description addresses this requirement. The MCO submitted a copy of the Approval letter that is sent to their members.	
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	P/P UM-004, Continuity Coordination of Care addresses this requirement.	
E. The Contractor shall have written policies and		Full	The MCO supplied the CCKY Tampa Metric Grid	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.			(Sep.Oct.Nov 2012) which details three months of activities including: Inpatient/Outpatient authorization and denials, IRR Scores, call center details, etc. UM description addresses this requirement.	
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.		Full	Coventry Cares provided the following executed contract agreements as evidence: <ul style="list-style-type: none"> • VSP • Avesis • MHNet. P/P UM – 021, Delegated Utilization Management addresses this requirement.	
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.		Substantial	P/P UM – 017, Monitoring of Over/Under Utilization not provided for review. UM Program 2011-2012 addresses this requirement. <u>Recommendation for Coventry Cares</u> The plan should provide requested documentation.	MCO Response: None
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	P/P UM-039, Prior Auth Review addresses this requirement. UM Program 2011-2012 addresses this requirement.	
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction		Full	Provider Satisfaction Survey Report addresses this requirement. The MCO advised that their	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
with the UM program as part of its satisfaction surveys.			first CAHPS survey results are due May 2013.	
The UM program will be evaluated by DMS on an annual basis.		Full	UM Program 2011-2012 addresses this requirement.	
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall give the Member written notice 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	P/P UM-008 addresses this requirement. P/P UM - 013 addresses this requirement. The MCO provided the following member letters as evidence: <ul style="list-style-type: none"> • Mem_Medicaid Appeal – Upheld Denial • Mem_Medical Partial Approval letter. P/P UM – 052, Timely Notification Administrative Denials addresses this requirement.	
(a) The action the Contractor has taken or intends to take;		Full	P/P UM-008 addresses this requirement.	
(b) The reasons for the action;		Full	P/P UM-008 addresses this requirement.	
(c) The Member's right to appeal;		Full	P/P UM-008 addresses this requirement. The MCO provided the following member letters as evidence: <ul style="list-style-type: none"> • Mem_Medicaid Appeal – Upheld Denial • Mem_Medical Partial Approval letter. Member Handbook – Grievance and Appeals addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 Member's right to request a State hearing;		Substantial	<p>The MCO provided the following member letters as evidence:</p> <ul style="list-style-type: none"> • Mem_Medicaid Appeal – Upheld Denial • Mem_Medical Partial Approval letter. <p>Member Handbook – Grievance and Appeals addresses this requirement.</p> <p><u>Recommendation for Coventry Cares</u> P/P APP – 002, Appeals Members should be revised to include this requirement.</p>	MCO Response: None
(e) Procedures for exercising Member's rights to appeal or file a grievance;		Full	<p>Policy UM008 Notice of Action addresses all requirements.</p> <p>The MCO provided the following member letters as evidence:</p> <ul style="list-style-type: none"> • Mem_Medicaid Appeal – Upheld Denial • Mem_Medical Partial Approval letter <p>Member Handbook – Grievance and Appeals addresses this requirement.</p>	
(f) Circumstances under which expedited resolution is available and how to request it; and		Full	<p>P/P UM-008 addresses this requirement. P/P APP – 001, Expedited Appeals policy addresses this requirement.</p> <p>Member Handbook – Grievance and Appeals addresses this requirement.</p>	
(g) The Member's rights to have benefits continue pending the resolution of the Appeal, how to		Substantial	<p>Member Handbook – Grievance and Appeals addresses this requirement.</p>	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.			Recommendation for Coventry Cares P/P UM-008, Notice of Action should be revised to include continuation of benefits.	
The Contractor must give notice 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	P/P UM – 013 addresses this requirement.	
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;		Full	P/P UM-008 addresses this requirement.	
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	P/P UM-008 addresses this requirement.	
3. The Member's admission to an institution where he is ineligible for further services;		Full	P/P UM-008 addresses this requirement.	
4. The Member's address is unknown and mail directed to him has no forwarding address;		Full	P/P UM-008 addresses this requirement.	
5. The Member has been accepted for Medicaid services by another local jurisdiction;		Full	P/P UM-008 addresses this requirement.	
6. The Member's physician prescribes the change in the level of medical care;		Full	P/P UM-008 addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;		Full	P/P UM-008 addresses this requirement.	
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	P/P UM-008 addresses this requirement.	
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.		Full	P/P UM-008 addresses this requirement.	
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	P/P UM-008 addresses this requirement.	
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		Full	P/P UM-008 addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
requires and no later than the date the extension expires.				
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) working days after receipt of the request for service.		Full	P/P UM-008 addresses this requirement.	
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.		Full	P/P UM-008 addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

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	45	4	0	0
Total Points	135	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		143/49=2.92		

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
36. Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix M, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. This plan shall include, at a minimum:		Full	Coventry Cares of Kentucky Program Integrity Plan and respective policies and procedures provided as described below.	
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;		Full	Coventry submitted several P/Ps demonstrating compliance including: COM-003, Program Integrity, addressing employee training, primary contact person, timeframes, monitoring tools and controls, and guidelines and procedures for detecting fraud; COM-004, Reporting of FWA; COM-005, Service Verification Process; and COM-09, Exclusion and Debarment Screenings.	
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;		Full	The Director of Policy and Compliance is the designated compliance officer. COM-001, Compliance Committee details the plan's compliance committee roles and responsibilities including its accountability to senior management.	
C. Effective training and education for the compliance officer, the organization's employees,		Full	Employee training records were provided. Online modules for Code of Business Conduct	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
subcontractors, providers and members regarding fraud, waste and abuse;			& Ethics, FWA training, and Privacy & Security training provided. Provider education is provided in the Provider Manual, newsletters and plan website. Coventry reviews subcontractor FWA programs and training records.	
D. Effective lines of communication between the compliance officer and the organization's employees;		Full	Employees are notified of their responsibility to report suspected violations and how and to whom to report such violations. The Compliance Officer communicates regularly with employees via newsletters, e-mails and lunch & learn sessions.	
E. Enforcement of standards through disciplinary guidelines;		Full	Disciplinary guidelines/actions are addressed in the Program Integrity Plan (PIP).	
F. Provision for internal monitoring and auditing of the member and provider;		Full	The following policies/procedures address internal monitoring and auditing: CoventryCares of Kentucky Program Integrity Plan; COM-001, Compliance Committee; COM-003, Program Integrity; COM-004, Reporting of Fraud Waste and Abuse; COM-005, Service Verification Process; and COM-009, Exclusion and Debarment Screening. FWA meeting agendas and minutes provided for: 2/12, 3/12, 4/12, 6/12, 7/12, 8/12, 9/12, 10/12, 11/12, 12/12. Minutes demonstrate active discussion and decisions related to individual cases and reports, as well as, review of trends and updates.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;		Full	Addressed in PIP.	
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	COM-006, Oversight of Delegated Subcontractors and Program Integrity Plan address oversight of subcontractors. Coventry provided subcontractor contracts including FWA provisions, as well as, subcontractor meeting agendas and minutes.	
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;		Full	Coventry provided evidence of submission of documentation to the Department and OIG.	
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	Addressed in PIP. Provider Outstanding Accounts Receivables reports, Report # 71 for 2012 provided.	
K. Contractor shall provide procedures for appeal process;		Full	Addressed in PIP.	
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	Addressed in COM-005, Service Verification Process.	
M. Contractor shall create a process for card sharing cases;		Full	Addressed in PIP and COM-004.	
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified,		Full	Use of algorithms addressed in PIP. Reports of SUR Algorithms (Report #75) provided.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	Addressed in PIP.	
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	Coventry reported attendance at the US Attorney General statewide healthcare fraud taskforce in April and November 2012.	
The plan shall be made available to the Department for review and approval.		Full	Coventry submitted their PIP during the readiness review.	
10.1 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	Coventry provided the following documents: position description for Director, Policy & Compliance, Coventry Cares of Kentucky Organizational Chart showing contract required positions, and notice to DMS of Compliance Director candidate.	



KY EQRO ANNUAL REVIEW
March 2013

Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	Addressed in position description for Director, Policy & Compliance.	
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:		Minimal	See sub-requirements below. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement. IPRO Comments: No change in review determination.
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;		Minimal	2012 Annual Disclosure of Ownership provided addressing Coventry Cares. Disclosure information for subcontractors not provided, only contract provisions. <u>Annual Disclosure Review</u> Coventry Health and Life Insurance Company: 10 officers identified, one name noted on EPLS; Coventry Cares should check accuracy of this finding with officer's SSN.	MCO Response: CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement. IPRO Comments: No change in review



KY EQRO ANNUAL REVIEW
March 2013

Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Coventry Health Care Inc.: 16 officers identified, none listed on excluded lists. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	determination.
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;		Minimal	2012 Annual Disclosure of Ownership provided addressing Coventry Cares. Disclosure information for subcontractors not provided, only contract provisions. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement. IPRO Comments: No change in review determination.
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 \$250,000 during the immediately preceding twelve-month period;		Full	Subcontract provisions address this requirement.	
D. A description of any significant business		Full	Addressed in 2012 Annual Disclosure of	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;			Ownership.	
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;		Minimal	Addressed in 2012 Annual Disclosure of Ownership for Coventry Cares. Disclosure information for subcontractors not provided. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement. IPRO Comments: No change in review determination.
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		Minimal	Addressed in 2012 Annual Disclosure of Ownership for Coventry Cares. Disclosure information for subcontractors not provided. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement. IPRO Comments: No change in review determination.
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall		Full	Coventry provided the following documents: Aetna Notice to DOI Aetna Notice to DMS	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.			Aetna Notice to DPH Aetna Notice to Cabinet	
State Contract, Appendix M				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;		Full	Addressed in PIP.	
B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;		Full	Addressed in PIP.	
C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;		Full	Compliance and SIU High Level Organizational Chart and SIU Organizational Chart provided showing staffing of SIU investigators including clinical and auditing staff. Coventry also has a dedicated SIU medical director and an active corporate Compliance Committee that includes local representation. The corporate Compliance Committee meets quarterly and the local FWA Committee meets monthly.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
D. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:		Non-Compliance	<p>Prioritization of cases not addressed in the documents provided.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>MCO Response: SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p>IPRO Comments: No change in review determination. The MCO should document the prioritization process in a policy/procedure.</p>
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;		Non-Compliance	See above.	<p>MCO Response: SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p>IPRO Comments: No change in review determination.</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(2) High dollar amount of potential overpayment; or		Non-Compliance	See above.	<p>MCO Response: SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p>IPRO Comments: No change in review determination.</p>
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.		Non-Compliance	See above.	<p>MCO Response: SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p>IPRO Comments: No change in review determination.</p>
E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends		Full	Addressed in PIP.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
including CMS initiatives;				
F. 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	Coventry attended US Attorney General statewide healthcare fraud taskforce in April and November 2012.	
FUNCTION: The Contractor shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:		Full	Addressed in PIP.	
A. Preventing 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	Addressed in PIP.	
B. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;		Full	Addressed in PIP. Report 75 shows use of SUR claims algorithms. Coventry uses Verisik software to mine claims and identify cases for investigation.	
C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;		Full	Addressed in PIP.	
D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;		Full	Addressed in PIP.	
E. Referring potential Fraud, Waste and Abuse cases		Full	Addressed in PIP.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
to the OIG (and copying DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;				
F. Initiating and maintaining 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	Addressed in PIP.	
G. Making and receiving recommendations to enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;		Full	Addressed in PIP.	
H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;		Full	Addressed in PIP.	
I. Providing for internal monitoring and auditing of Contractor and its subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;		Minimal	<p>Internal monitoring and auditing are addressed in the PIP. Provision of quarterly reports to the Department related to subcontractors is noted. It is not evident that Coventry Cares reports internal monitoring and auditing activities for the Contractor itself.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>MCO Response: The plan has launched a Service Advisory Oversight Committee for internal monitoring and audits, as necessary. The organizational meeting was held on April 17, 2013. The next quarterly meeting is scheduled for July 31, 2013. The Service Advisory Committee members and responsibilities are enclosed. Service Advisory Committee Minutes are reported to the Executive Quality Improvement Committee. Minutes of the EQIC are reported to the Department as part of routine state reporting.</p> <p>IPRO Comments: No change in review determination.</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
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J. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and		Full	Addressed in PIP.	
K. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department.		Full	Addressed in PIP and Report 71 provided showing such activity.	
The Contractor's PIU shall:				
A. 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	Addressed in PIP. Report 75 provided.	
B. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG;		Full	Addressed in PIP. Report 76 provided.	
C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;		Full	Addressed in PIP. Report 76, Provider Fraud Waste and Abuse provided.	
D. Maintain locally 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	Addressed in PIP. Coventry also provided screen shots of the plan's Case Tracking Database and Report 76.	
E. Designate a contact person to work with investigators and attorneys from the Department and OIG;		Full	Director of Policy and Compliance is the designated contact person.	
F. Ensure the integrity of PIU referrals to the		Full	Addressed in PIP.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Department. Referrals if appropriate by the unit shall not be subject to the approval of the Contractor's management or officials;				
G. 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	Addressed in PIP and P/P COM-005 Service Verification Process.	
H. Run algorithms on claims data and develop a process and report quarterly to the department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;		Full	Addressed in PIP. Reports 76 and 75 provided.	
I. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;		Full	Addressed in PIP and Report 73, Member Program Violation provided.	
J. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;		Full	Addressed in PIP.	
K. Report any provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, to the Department within 5 days of the enrollment denial;		Minimal	Coventry noted CP-012 Provider Terminations and Member Moves as evidence, however this document was not provided. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective	MCO Response: Please see emails to DMS which document the reporting and the reason for termination or denied enrollment. IPRO Comments: Review determination changed to Minimal. Coventry (CVTY) Provider Terms report for 12/12 provided demonstrating reporting to DMS. Process



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	should be documented in a policy/procedure.
L. Have a method for recovering overpayments from providers;		Full	Addressed in PIP.	
M. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;		Full	Addressed in PIP.	
N. 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 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; and		Full	Addressed in PIP. P/P Fraud Plan Revision Policy includes annual evaluation of the effectiveness of the Anti-FWA plan.	
O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.		Full	Addressed in PIP.	
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services and OIG.		Non-Compliance	Addressed in PIP: states that cases involving member safety (abuse) are reported to the health plan medical director for review. Does not address requirement for notifying DCBS, DMS and OIG. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO	MCO Response: Please see the new policies which will be submitted through the Policies & Procedures Committee for review and approval. IPRO Comments: No change in review determination.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
COMPLAINT SYSTEM: The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process 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	Addressed in PIP.	
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	Addressed in PIP.	
C. Should the preliminary inquiry result 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 should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;		Full	Addressed in PIP.	
D. Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred,		Full	Addressed in PIP.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
the PIU should refer the case and all supporting documentation to the Department, with a copy to OIG;				
E. OIG will review the referral and attached documentation and make a determination as to whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;		Full	Addressed in PIP.	
F. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;		NA	OIG responsibility.	
G. If in the process of conducting a preliminary investigation, the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG;		Full	Addressed in PIP.	
H. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to the Department and the PIU for appropriate actions;		NA	OIG responsibility.	
I. If OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;		NA	OIG responsibility.	
J. If OIG investigation results in a referral to the		NA	OIG responsibility.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PIU of the referral. DMS and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
K. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;		Full	Addressed in PIP.	
L. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:		Substantial	Addressed in PIP. A sample of 10 program integrity files were reviewed - 5 member files, 4 provider files and one ancillary provider file. Sub-requirement results are presented below. One file appeared untimely: file indicates that the case was closed on 7/13/12 with referral to OIG; referral to OIG sent 11/15/12. <u>Recommendation for Coventry Cares</u> The MCO should ensure that case investigations proceed to closure in a timely manner.	MCO Response: None
(1) Name and address of subject,		Full	10 of 10 files were compliant.	
(2) Medicaid identification number,		Full	10 of 10 files were compliant.	
(3) Source of complaint,		Substantial	9 of 10 files were compliant. One file states	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			that a referral was received, however the source of the referral is not specified. <u>Recommendation for Coventry Cares</u> The source of referral should be clearly documented in program integrity files.	
(4) The complaint/allegation,		Full	10 of 10 files were compliant.	
(5) Date assigned to the investigator,		Full	10 of 10 files were compliant.	
(6) Name of investigator,		Substantial	9 of 10 files were compliant. One file did not include the name of the investigator. <u>Recommendation for Coventry Cares</u> The name of the investigator should be clearly documented in program integrity files.	MCO Response: None
(7) Date of completion,		Full	10 of 10 files were compliant.	
(8) Methodology used during investigation,		Full	10 of 10 files were compliant.	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,		Non-Compliance	Files presented included a timeline of activities. A summary of attachments (listing all items pertaining to the investigative report) was not included in the files. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Most cases reviewed were referrals from the Commonwealth. The member and/or provider are determined not to be associated with CoventryCares of Kentucky. For a full investigation, please see the attached file which contains facts and supporting documentation. IPRO Comments: No change in review determination. Complete files were not available at the time of review.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(10) All exhibits or supporting documentation,		Substantial	Supporting documentation was not evident in all the files provided. For example, the letter to the OIG was not included (one case); letter to the provider for recovery not included (one case). <u>Recommendation for Coventry Cares</u> Coventry Cares should ensure that case files include all supporting documentation.	MCO Response: None
(11) Recommendations as considered necessary, for administrative action or policy revision,		Full	Files reviewed were compliant.	
(12) Overpayment identified, if any, and recommendation concerning collection.		Substantial	In one file, the MCO approved recovery of \$6,556.85 on 11/18/12. Recovery submitted and education letter sent on 12/10/12 however these documents are not included in the file. File indicates that the case is closed however status/outcome of recovery is not documented. <u>Recommendation for Coventry Cares</u> Coventry Cares should ensure that case files include a listing of all pertinent documents and interviews conducted during the investigation.	MCO Response: None
M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;		Full	Reports 76 and 77 provided.	
N. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a		Full	Addressed in PIP.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
particular complaint or grievance process or the status of a specific recoupment; and				
O. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.		Full	Addressed in PIP.	
REPORTING: The Contractor's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure. If any internal component 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 report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG.		Full	Fraud Waste and Abuse Committee agendas and minutes provided. Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
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	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(1) PIU Case number;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(2) OIG Case number;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(3) Provider/Member name;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			investigations.	
(4) Provider/Member number;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(5) Date complaint received by Contractor;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(6) Source of complaint, unless the complainant prefers to remain anonymous;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(7) Date opened;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(8) Summary of complaint;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(10) PIU action taken (only provide the most current update);		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(11) Amount of overpayment (if any);		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(12) Administrative actions taken to resolve findings of completed cases including the following		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
information:			investigations.	
(a) The overpayment required to be repaid and overpayment collected to date;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(b) Describe sanctions/withholds applied to Providers/Members, if any;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(c) Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(d) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
(e) Make MIS system edit and audit recommendations as applicable.		Full	Reports 76 and 77 provided demonstrating reporting of member and provider FWA investigations.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, keep 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		Non-Compliance	Coventry noted that this is addressed in the plan's Record Retention Policy, however this policy was not provided for review. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract	MCO Response: CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. Please see ADOs that have been received to date which are enclosed. Additionally, COM-006 Delegated Vendor



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Oversight policy has been updated to reflect annual reporting requirement. IPRO Comments: No change in review determination.
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;		Full	P/P GEN-004 Encounter Data Submission provided. Coventry submits Member Mismatch File and Provider File weekly.	
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;		Full	Not addressed in the documents provided. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: CoventryCares of Kentucky provides documentation to the Department and OIG upon request. IPRO Comments: Review determination changed to Full as Coventry indicates that documentation is provided upon request.
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or 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	Coventry indicated that the plan provides access upon request as required by the contract.	
E. Produce records in electronic format for review and manipulation by the Department and the OIG;		Full	Coventry indicated that the plan provides access upon request as required by the contract.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and		Full	CoventryCares of Kentucky has made an agreement with the Cabinet to allow DMS staff on site with read only access during regular business hours with advanced notice. Both contracts for all 8 Regions reflect this agreement.	
G. Provide all contracted rates for providers upon request.		NA	Per Coventry, this is proprietary information that would provide an unfair competitive advantage and the plan has not been required by DMS to respond to any requests.	
The Contractor's PIU shall have access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.		Full	Addressed in PIP.	
The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or abuse cases.		Full	Addressed in PIP.	
In the event no action toward collection of overpayments is taken by the Contractor after one hundred and eighty (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the Contractor takes appropriate action to collect overpayments, the Commonwealth will not intervene.		Non-Compliance	Not addressed in the documents provided. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Collection amounts and amounts collected are provided on state report # 72 monthly. This is a DMS action. Report #72 is enclosed. IPRO Comments: No change in review determination. Collection activity reported in Report #72 (dated 2013).
The Contractor shall provide identity and cover		Non-Compliance	Per Coventry this was discussed with DMS,	MCO Response: This is not a contract



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Program Integrity <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
documents and information for law enforcement investigators under cover.			and the plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	requirement. Further, CoventryCares of Kentucky cooperated with the MFCU and Cabinet to provide the credentials in spring 2012. The Cabinet took the matter under advisement. No further action or request has been made since that time. IPRO Comments: No change in review determination.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	96	5	7	9
Total Points	288	10	7	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		305/117=2.61		

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



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

**Program Integrity
Suggested Evidence**

Documents

Policies/Procedures for:

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

Program Integrity Plan including related policies and procedures

Program Integrity training program and evidence of training for Compliance Officer, staff, providers, subcontractors and members

Program Integrity Unit description including Compliance Officer position description

Program Integrity Committee description and minutes

Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees

Provider contract provisions for FWA

Vendor contract provisions for FWA

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data

Monthly state reporting

Quarterly Program Integrity Reports

File Review

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

ADO files selected by EQRO



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
8.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)				
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. 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 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.		Full	Addressed in P/P UM-047, EPSDT and EPSDT Program Description. Quarterly MCO Reports #24 were provided. With the exception of Q1 2012, the reports for Q2, Q3 and Q4 2012 did not include CMS Form 416. These reports included the number of members screened by EPSDT code. The Q1 reports included screening and participation ratios for Family Choices and Global Choices. The ratios were reported by age group. <u>Recommendation for DMS</u> It is suggested that the MCO reporting requirements be revised to include quarterly reporting of CMS Form 416 as a component of MCO report #24.	MCO Response: None DMS Response: DMS will review reporting recommendations to update MCO report #24 to assure that screening and participation elements reflect MCO Contract Special Program Requirements in 32.1 for EPSDT quarterly CMS 416 reporting. An additional MCO report, #93, requires annual EPSDT CMS 416 reporting. Screening and participation elements are available from this report on an annual basis as currently reported. Report #93 must be updated to reflect the requirement for quarterly reporting. DMS will provide follow up regarding MCO reports #24 and #93 report revision timelines.
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:		Full	P/P UM-047 and the Provider Manual address this requirement.	
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.		Minimal	P/P UM-047 and Provider Manual address this requirement. Q3 2012 MCO #24 report references an EPSDT Provider Reference Manual that was pending committee approval. It is not evident whether this manual has been approved or made available to providers.	MCO Response: 1) The EPSDT Provider Manual was approved by the plan's Communications Review Team (CRT) on April 1, 2013. The EPSDT Provider Manual has been posted to the plan's website. The availability of the manual will be announced to providers through a Fax Blast, email and mail distribution to 3,000 Pediatric



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>Evidence of provider training was not provided. The adequacy of the provider network to provide accessible and fully trained EPSDT providers was not addressed in the documents provided.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>Providers and 800 health department offices throughout Kentucky. 2) The distribution of the EPSDT Provider Manual along with quarterly EPSDT updates in the Provider Newsletter will serve as the primary educational approach for Providers. 3) To provide access to the EPSDT Team members, the plan has shared the key contact names and numbers of the EPSDT Team Members for any questions or concerns. 4) The plan's Provider Relations and Quality Outreach staff will serve as additional subject matter sources for the Providers. 5) Provider Relations Team EPSDT dedicated training session were held on 6/21/13.</p> <p>CoventryCares of Kentucky does not require special classification of EPSDT providers. Providers who are eligible under their license to provide services are permitted to provide EPSDT services to CoventryCares of Kentucky members.</p> <p>IPRO Comments: No change in review determination.</p>
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		Full	<p>P/P QI-017 and Member Handbook address this requirement.</p> <p>Coventry also addresses this requirement in several outreach documents, including:</p> <ul style="list-style-type: none"> • Adolescent Immunizations member 	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
services, and the Member's right to access these services.			letter <ul style="list-style-type: none"> • Adolescent Well Care - Ages 18+ member letter • Childhood Access to PCPs member letter • Childhood Immunizations member letter • Dental Care member letter • Well Child Checkup • Kidshealth brochure • Birth card teen • EPSDT Reminder • Birthday card youth Quarterly reports (MCO report #24) for Q1-Q4 2012 describe outreach efforts including: automated outreach calls for missed appointments, and reminder letters.	
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.		Substantial	Member Handbook includes the member's right to appeal decisions related to Medicaid services, but does not specify EPSDT services. P/P QI -017 addresses this requirement. <u>UM File Review</u> Five UM decisions related to EPSDT (child members) were reviewed. All 5 files were completed timely and were compliant with UM contract requirements. <u>Appeal File Review</u> Five member appeals related to EPSDT (child members) were reviewed. No	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>documentation was provided in the file for one case. Another file lacked an acknowledgment letter. The remaining 3 files were completed timely and were compliant.</p> <p><u>Recommendation for Coventry Cares</u> The Member Handbook should include appeal rights for EPSDT services. Appeal files should include complete documentation including acknowledgement letters.</p>	
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.		Full	<p>P/P UM - 047 and P/P CM – 025 address this requirement.</p> <p>The EPSDT Coordinator conducts quarterly quality audits of high volume providers to assess member compliance with EPSDT well child screening, and to determine if providers are compliant with member follow-up on referrals as a result of EPSDT screening.</p> <p>The MCO also provided the following documents:</p> <ul style="list-style-type: none"> • Provider Adolescent Immunization Record Form • Childhood Immunization Record Form. 	
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete		Full	<p>P/P UM-047 addresses this requirement. Provider Manual addresses this requirement.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.				
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 may provide treatment if the service is not available with the Contractor's Network.		Full	P/P UM-047 and P/P CM-025 address this requirement.	
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	P/P UM-047 and P/P CM-025 address this requirement. Provider Manual addresses this requirement.	
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.		Minimal	<p>P/P UM-047 addresses tracking of acceptance and refusal of EPSDT services. Evidence of monitoring of receipt/non-receipt of services provided. Evidence of tracking system for monitoring acceptance and refusal of EPSDT services by members was not provided.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>MCO Response: CoventryCares of Kentucky is implementing the following actions to address this finding:</p> <ol style="list-style-type: none"> 1) Develop a tracking system to report and monitor acceptance and refusal of: <ol style="list-style-type: none"> a) EPSDT screening and b) EPSDT Special Services 2) Utilize existing monthly reports for tracking of: <ol style="list-style-type: none"> a) Lack of compliance based on frequency of missed visits b) Listing of members with non-assigned Provider and lack of compliance and c) Any member or family who refuses EPSDT Services



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				<p>3) Implement scheduled member outreach process based on identification of EPSDT visit non-compliance at high level threshold.</p> <p>This is will be accomplished through a system enhancement to NavCare System to add EPSDT data fields for tracking of EPSDT coordinator outreach and follow-up. The request has been submitted and development meetings are scheduled.</p> <p>IPRO Comments: No change in review determination.</p>
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.		Full	<p>P/P CM - 025 addresses this requirement.</p> <p>Coventry Cares uses automated outreach calls and reminder mailings to inform members of services due.</p> <p>Coventry provided a report (undated), titled Kentucky Clinical Notifications, January-December 2012. This report shows the number of follow-up calls and notifications made on a monthly basis as well as the outcome: already had appointment, already scheduled appointment, promised to schedule appointment, assisted with scheduling, no commitment and declines contact.</p>	
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information		Full	<p>P/Ps CM - 025 and UM – 047, and Provider Manual address this requirement.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
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.				
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	Addressed in MH Net contract amendment. The Coordination of Care Screening and Referral form was provided. This form allows for sharing of information between physical and behavioral health providers. Policy UM - 047 EPSDT also addresses this requirement.	
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	P/P UM-047 addresses this requirement.	
K. Participate in any state or federally required chart audit or quality assurance study.		Full	P/P QI-015, Medical Record Review addresses this requirement. Provider Manual addresses this requirement.	
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		Minimal	P/P UM-047 and the Provider Manual address this requirement. Upon employment with the MCO and annually, customer service and case management staff attend EPSDT training.	MCO Response: 1) The EPSDT Provider Manual was approved by the plan's Communications Review Team (CRT) on April 1, 2013. The EPSDT Provider Manual has been posted to the plan's website. The availability of the manual will be announced to providers through a Fax Blast, email and



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
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.			<p>A formal educational seminar was provided to case management staff.</p> <p>Per the Q3 2012 MCO Report #24, the plan developed an EPSDT Provider Reference Manual that is awaiting committee approval.</p> <p>Evidence of provider training was not provided.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>mail distribution to 3,000 Pediatric Providers and 800 health department offices throughout Kentucky.</p> <p>2) The distribution of the EPSDT Provider Manual along with quarterly EPSDT updates in the Provider Newsletter will serve as the primary educational approach for Providers.</p> <p>3) To provide access to the EPSDT Team members, the plan has shared the key contact names and numbers of the EPSDT Team Members for any questions or concerns.</p> <p>4) The plan's Provider Relations and Quality Outreach staff will serve as additional subject matter sources for the Providers.</p> <p>5) Provider Relations Team EPSDT dedicated training session were held on 6/21/13.</p> <p>CoventryCares of Kentucky does not require special classification of EPSDT providers. Providers who are eligible under their license to provide services are permitted to provide EPSDT services to CoventryCares of Kentucky members.</p> <p>IPRO Comments: No change in review determination.</p>
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department,		Full	Coventry provided the EPSDT Encounter Data report as evidence for this	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.</p>			<p>requirement.</p> <p>The MCO reported that the quarterly and annual 416 reports are not due until March 2013. The quarterly MCO #24 reports were provided.</p> <p>Annual 416 report was submitted to DMS in March 2013. Coventry Cares reported an EPSDT screening rate of 96% total (Categorically Needy and Medically Needy). Across age groups, the screening rate ranged from 6% (19-20 years of age) to 100% (age < 1 year, 1-2 years of age and 3-5 years of age). Coventry Cares reported an EPSDT participation rate of 47% total (Categorically Needy and Medically Needy). Across age groups, the participation rate ranged from 3% (19-20 years of age) to 88% (age < 1 year). The report also includes the screening and participation rates for individual categories – Categorically Needy and Medically Needy.</p>	
<p>N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.</p>		<p>Minimal</p>	<p>The MCO provided an Overview of EPSDT Coordinator Functions as evidence for this requirement. This document is not dated; not a formal position description.</p> <p>The EPSDT liaison position is vacant on the organizational chart provided. The EPSDT nurse position is staffed.</p> <p><u>Corrective Action Plan</u></p>	<p>MCO Response: The Medicaid Managed Care Contract states in Section 10.1, "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. Responsibility for these functions or staff positions may be provided by, combined with or split among Contractor's departments, people or</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	<p>Subcontractors and carry such titles as Contractor designates and provides to the Department.”</p> <p>The role of EPSDT Coordinator is filled by multiple staff. The appointed ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services. Ms. Moorhead has deep experience in working with pediatric and neonatal providers and members. She leads our EPSDT initiative and uses the talents and skills of other clinical and clerical staff to track and monitor the EPSDT population.</p> <p>Please see the enclosed Organizational Chart.</p> <p>IPRO Comments: No change in review determination.</p>
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.		Non-Compliance	<p>The MCO provided an Overview of EPSDT Coordinator Functions as evidence for this requirement. This document is not dated; is not a formal position description and does not address the required function as stated in the contract requirement.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the</p>	<p>MCO Response: The Medicaid Managed Care Contract states in Section 10.1, “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. Responsibility for these functions or staff positions may be provided by, combined with or split among Contractor’s departments, people or</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i>				
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			<p>MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>Subcontractors and carry such titles as Contractor designates and provides to the Department.”</p> <p>The role of EPST Coordinator is filled by multiple staff. The appointed ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services. Ms. Moorhead has deep experience in working with pediatric and neonatal providers and members. She leads our EPSDT initiative and uses the talents and skills of other clinical and clerical staff to track and monitor the EPSDT population.</p> <p>Please see the enclosed Organizational Chart.</p> <p>IPRO Comments: No change in review determination.</p>
37.9 EPSDT Reports				
<p>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.</p>		<p>Full</p>	<p>Coventry provided the EPSDT Encounter Data report as evidence for this requirement.</p> <p>Quarterly CMS 416 reports not provided with the exception of Q1 2012. This report did not provide overall screening and participation ratios.</p> <p>Annual report was submitted to DMS in</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i>				
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			<p>March 2013. Coventry Cares reported an EPSDT screening rate of 96% total (Categorically Needy and Medically Needy). Across age groups, the screening rate ranged from 6% (19-20 years of age) to 100% (age < 1 year, 1-2 years of age and 3-5 years of age). Coventry Cares reported an EPSDT participation rate of 47% total (Categorically Needy and Medically Needy). Across age groups, the participation rate ranged from 3% (19-20 years of age) to 88% (age < 1 year). The report also includes the screening and participation rates for individual categories – Categorically Needy and Medically Needy.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

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	14	1	4	1
Total Points	42	2	4	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		48/20=2.40		

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



KY EQRO ANNUAL REVIEW March 2013

Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Suggested Evidence

Documents

Policies/procedures for:

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

EPSDT member/provider ratio and case management ratio for EPSDT children with special needs

Evidence of communication of required EPSDT information with eligible members and families

EPSDT Coordinator position description

Description of tracking system to monitor acceptance and refusal of EPSDT services

Process for monitoring compliance with EPSDT services requirements including periodicity schedule

Evidence of case management function providing education and counseling for patient compliance

Process for ensuring follow-up evaluation, referral and treatment in response to EPSDT screening results

Linkage agreements between MCO providers and behavioral health providers to assure provision of EPSDT services

Copies of practitioner training materials and other educational/informational materials and attendance records

Process for calculating EPSDT participation and screening rates including quality control measures

Evidence of submission of EPSDT Encounter Records, including special EPSDT procedure codes and referral codes

File Review

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

Reports

EPSDT reports (quarterly and annual 416 reports)

Annual EPSDT report of EPSDT activities, utilization and services



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
5.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.			Coventry Cares subcontracts with 8 entities including: American Specialty Health (ASH) – chiropractic services Medco – pharmacy services National Imaging – radiology services Triad – musculoskeletal pain management services Avesis – dental services McKesson – advice line MH Net – behavioral health services VSP – vision services Coventry Cares also contracts with National Research Corporation (NRC) for conduct of Health Risk Assessments for its Kentucky members, and with Chamberlain Edmonds to identify members who may qualify for SSI.	
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.		Full	Coventry Cares has written agreements with all 8 entities and the agreements are compliant with the specified requirements.	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.		Substantial	Pre-delegation audits were provided for all subcontractors with the exception of ASH: Coventry Cares provided a pre-delegation audit dated 3/18/13. The	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

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			<p>audit indicates that the MCO has had a contract with ASH since November 2011. A pre-delegation audit prior to the date of delegation was not provided.</p> <p><u>Recommendation for Coventry Cares</u> The MCO should explain the discrepancy between the date of delegation and the pre-delegation audit date.</p>	
<p>C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.</p>		<p>Minimal</p>	<p>Coventry Cares maintains a Subcontractor Oversight Committee. During the transition period, the MCO met weekly with subcontractors, eventually reducing to biweekly and currently monthly meetings.</p> <p>Documentation of oversight, ongoing and formal review, was provided for Medco (annual audit December 2012) and Avesis (annual audit October 2012). Evidence of ongoing monitoring and/or an annual audit was lacking for the following:</p> <p>ASH: Coventry Cares provided copies of meeting agendas and minutes for 2012/2013. Performance standard reports were not provided. MCO Report 15 indicates that penalties were</p>	<p>MCO Response: CoventryCares of Kentucky has completed the delegation audits of ASH and Avesis. Reports to the Executive Quality Improvement Committee on the audits are included.</p> <p>CoventryCares of Kentucky has recently reorganized its structure related to delegated vendor/subcontractor oversight. A new director for Network Development has been hired and will take the lead in Subcontractor Oversight. To prepare for this transition, the Compliance Department and Quality Improvement Department have prepared summaries of individual subcontractor contract deliverables and NCQA requirements. Monthly meetings are scheduled with each subcontractor. Further, bi-monthly meetings of the</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

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			<p>assessed for failure to meet timely claims processing standards and for not providing electronic encounter records. Follow-up regarding this issue was not evident in the documents provided. The MCO noted that the annual audit for ASH is currently in process.</p> <p>National Imaging: The annual audit for 2012 (reported January 2013) was provided. Evidence of ongoing oversight including monitoring of subcontractor reporting was not provided.</p> <p>Triad: Evidence of ongoing oversight including monitoring of subcontractor reporting was not provided. Annual audit not due yet.</p> <p>McKesson: Evidence of ongoing oversight including monitoring of subcontractor reporting not provided. Annual audit conducted (November 2012).</p> <p>MHNet: Evidence of ongoing oversight including monitoring of subcontractor reporting not provided. Annual audit conducted (October 2012).</p> <p>VSP: Evidence of ongoing oversight</p>	<p>Subcontractor Oversight Committee are scheduled in which the plan's contract liaisons will report on each subcontractor's performance. The Committee will review the performance and make recommendations for improvement and where appropriate, corrective action.</p> <p>IPRO Comments: No change in review determination.</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

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			subcontractor reporting provided. Evidence of annual audit not provided. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.		Minimal	Areas of deficiency identified during annual audits resulted in corrective action plans. Results of ongoing monitoring for several subcontractors was not provided; it is not clear whether corrective actions are in place in response to regular reporting for these entities. ASH was assessed penalties as described above. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan	MCO Response: Please see corrective action plan monitoring for ASH and Aveis. IPRO Comments: No change in review determination.



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

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			to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.		Full	All agreements are compliant.	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.		Minimal	See sub-elements above. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Please see corrective action plan monitoring for ASH and Aვის. I PRO Comments: No change in review determination.
7.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for		Full	8/8 of contracts are compliant.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
the payment of any debt of or the fulfillment of any obligation of the Subcontractor.				
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.		Full	8/8 of contracts are compliant.	
7.2 Requirements				
All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not		Full	8/8 of contracts are compliant. Coventry Cares reports that DMS has approved the MCO's subcontractor template.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.				
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;		Full	8/8 of contracts are compliant.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;		Full	8/8 of contracts are compliant.	
C. Specify procedures and criteria for extension, renegotiation, and termination;		Full	8/8 of contracts are compliant.	
D. Specify that Subcontractors use only Medicaid providers in accordance with this Contract;		Full	8/8 of contracts are compliant.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;		Full	8/8 of contracts are compliant.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;		Full	8/8 of contracts are compliant.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;		Full	8/8 of contracts are compliant.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;		Full	8/8 of contracts are compliant.	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;		Full	8/8 of contracts are compliant.	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;		Full	8/8 of contracts are compliant.	
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,		Full	8/8 of contracts are compliant.	
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and		Full	8/8 of contracts are compliant.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,				
(2) all QAPI requirements,		Full	8/8 of contracts are compliant.	
(3) all record keeping and reporting requirements,		Full	8/8 of contracts are compliant.	
(4) all obligations to maintain the confidentiality of information,		Full	8/8 of contracts are compliant.	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,		Full	8/8 of contracts are compliant.	
(6) all indemnification and insurance requirements, and		Full	8/8 of contracts are compliant.	
(7) all obligations upon termination;		Full	8/8 of contracts are compliant.	
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;		Full	8/8 of contracts are compliant.	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.		Substantial	7/8 of contracts are compliant. NCQA certificate for VSP expired 5/3/12. <u>Recommendation for Coventry</u>	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Cares Current accreditation certificates and survey reports should be maintained for each subcontractor.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.		Full	8/8 of contracts are compliant.	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.		Full	8/8 of contracts are compliant.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.		Full	8/8 of contracts are compliant.	
Section 7.2 requirements would be applicable to Subcontractors characterized as Providers/Risk Arrangements including, but not limited to, physicians, hospitals, ancillary providers, IPAs/PHOs, Provider Networks, and Vision Care, Dental and Behavior Health Services; and to those who interact and assist Members including, but not limited to, Radiology Benefit Manager, Disease Management/Case Management, Health Risk Assessments, Pre-Certification Services, PBM, Recoveries, Translation Services and 24-hour Section 7.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.		Full	8/8 of contracts are compliant.	
7.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any		Non-Compliance	Coventry Cares did not address this	MCO Response: CoventryCares of



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of \$250,000 or five percent (5%) of the Subcontractor's operating expense.			<p>requirement in the documentation provided.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>Kentucky has requested annual disclosure of ownership (ADO) information from its Subcontractors. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address. ADOs that have been received to date are included.</p> <p>IPRO Comments: No change in review determination.</p>
7.4 Remedies				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.		NA	DMS responsibility.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	28	2	3	1
Total Points	84	4	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		91/34=2.68		

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



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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

Documents

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

Reports

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
2. Definitions				
<u>Care Coordination</u> means the integration of all processes in response to a Member's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.				
<u>Care Management System</u> includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.				
<u>Care Plan</u> means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
<u>Case Management</u> is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
<i>Children with Special Health Care Needs</i> means Members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount that is beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
<i>CHIPRA</i> means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue their existing program and expands insurance coverage to additional low-income, uninsured children.				
<i>Comprehensive Assessment</i> means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a		Full	Coventry employs clinical health coordinators, complex case managers, social workers and health services managers.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Member.				
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.		Full	Addressed in P/P CM 006, Referral Resources; CM 004, Complex Case Management and CM 021, HRA.	
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.		Full	Addressed in P/P UM 004, Continuity and Coordination of Care.	
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.		Non-Compliance	Linkage of care coordination with other contractor systems not addressed in the policies provided. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: The current policy (UM-004) has been updated to reflect the on-going coordination of care activities related to quality of care, quality of service, grievances and appeals, case management referrals, adverse events and member service inquiries. Initial policies were prospective based on the start-up nature of the health plan. Processes have evolved as the plan has matured. Please see the revised UM-004 policy as attached. IPRO Comments: No change in review determination.
34.3 Care Coordination				
The care coordinators and case managers will work together with the primary care providers as teams to		Full	Addressed in P/P UM 004.	DMS Response: DMS agrees with IPRO's recommendation. Appropriate files will be



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
provide appropriate services for Members.			<p><u>Care Coordination File Review</u> 20 of 20 care coordination files reviewed included evidence of identification of physical and behavioral health needs and facilitation and coordination of services as needed.</p> <p><u>Recommendation for DMS</u> It is suggested that future file reviews include a subset of members enrolled in complex case management. Although the files selected for review included members with multiple chronic conditions, their conditions were relatively stable. It would be useful to assess the effectiveness of services provided to members with more complex needs.</p>	requested from each MCO for the next compliance review.
Care coordination is a process to assure that the physical and behavioral health needs of the 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	Addressed in P/P CM 017, Case Management of Persons with Special Needs.	
The Contractor shall identify a Member with special health care needs, including but not limited to Members		Full	Addressed in P/P CM 017.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
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	Addressed in P/P CM 017. <u>Care Coordination File Review</u> 20 of 20 care coordination files reviewed included completed comprehensive assessments.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.		Full	Addressed in P/P 005, Complex Case Management – Case Plan. <u>Care Coordination File Review</u> 20 of 20 care coordination files reviewed included care plans with established goals. Care plans and goals were updated as necessary.	
The Contractor shall develop and implement policies and		Non-Compliance	Coventry provided Report 65, Foster Care	MCO Response: CM-011 has been updated to



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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 satisfaction with care and services specific to the DCBS population.			Report as evidence. This report provides information on members in foster care including enrollment in case management, and disease management, completion of health risk assessments. It does not address measurement of utilization, access, complaints and grievances and satisfaction for this population. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	reflect utilization, access, complaints and grievances as well as satisfaction. Please also see Policy UM-004, CM-010 and UM-017. IPRO Comments: No change in review determination.
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	Addressed in the Member Handbook and Provider Handbook.	
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,				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	Addressed in the following P/Ps: CM 017, CM 010 (Access to Special Needs Providers), and UM 001 (Collaborative Case Management Process – Behavioral Health).	
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	Addressed in P/P CM 017 and CM 010.	
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	Addressed in P/P CM 017 and CM 010.	
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		Full	Addressed in P/P CM 017 and UM 001.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
chronic physical health illnesses; and individuals with chronic behavioral health illnesses.				
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	Addressed in P/P CM 017.	
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.		Full	Addressed in P/P CM 017.	
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	Addressed in P/P CM 017 and CM 005.	
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	Clinical Practice Guidelines provided demonstrate consideration of ISHCN.	
35.2 DCBS Protection and Department for Aging and Independent Living DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be		Minimal	Addressed in P/P CM 017. Reports 65 and 66 provided.	MCO Response: Please see Policy CM-017 which has been updated to reflect the process



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>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.</p>			<p><u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services.</p> <p>Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate.</p> <p><u>DCBS Claims File Review</u> IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination files for selected members were requested.</p> <p>Twenty files were reviewed with the following results:</p>	<p>for obtaining services plans for DCBS and DAIL clients.</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, Coventry Cares requested DCBS schedule monthly meetings to discuss and sign off on service plans.</p> <p>Claim specific to EPSDT service code for one file was located in the Navigator system. Evidence is enclosed.</p> <p>EPSDT outreach includes reminders for needed EPSDT visits with the provider. The letters are automatically uploaded to the Navigator system. See enclosed documentation for original dates of outreach.</p> <p>IPRO Comments: No change in review</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>13 of 20 files included evidence of at least one well visit during the review period. Of the remaining 7 files, 4 files lacked evidence of a well visit and 3 files were not applicable (2 members were not due for a well visit and one member was hospitalized in a NICU).</p> <p>Of the 13 files including a well visit, provision of EPSDT services was evident in 12 files (one file - claims did not show evidence of an EPSDT service code).</p> <p>Outreach efforts were not evident in the 5 files lacking a well visit and/or EPSDT service claim.</p> <p>Care coordination was evident in 7 files reviewed. The remaining 13 files did not require care coordination services.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>determination.</p> <p>DMS Response: DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for DMS</u> Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The MCOs are responsible for ongoing care coordination for these members including assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	
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.		Non-Compliance	P/P CM 017 indicates that individual in adult guardianship have separate policies, however these were not provided for review. <u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: Policy CM-012 has been revised and is enclosed for review. The updated policy will be presented to the Policies & Procedure Committee for review and approval. IPRO Comments: No change in review determination.
35.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in		Minimal	Addressed in P/P CM 011, Case	MCO Response: Please see Policy CM-017



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.</p>			<p>Management for Members in Foster Care and Members Receiving Adoption Services.</p> <p><u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services.</p> <p>Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS</p>	<p>which has been updated to reflect the process for obtaining service plans for DCBS and DAIL clients.</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, CoventryCares requested DCBS schedule monthly meetings to discuss and sign off on service plans.</p> <p>IPRO Comments: No change in review determination.</p> <p>DMS Response: DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p> <p><u>Recommendation for DMS</u> Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The MCOs are responsible for ongoing care coordination for these members including assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services</p>	<ul style="list-style-type: none"> ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
			needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	
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.		NA	Addressed in P/P CM 017 and CM 011. <u>DCBS Service Plan File Review</u> None of the files reviewed required case management services.	
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.		NA	Addressed in P/P CM 011. <u>DCBS Service Plan File Review</u> None of the files reviewed required case management services.	
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		Minimal	Addressed in P/P CM 011. <u>DCBS Service Plan File Review</u>	MCO Response: Please see Policy CM-011 which has been updated to reflect the process for obtaining services plans for DCBS and DAIL



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination
(See Final Page for Suggested Evidence)

State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.</p>			<p>Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services.</p> <p>Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>clients.</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, CoventryCares requested DCBS schedule monthly meetings to discuss and sign off on service plans.</p> <p>IPRO Comments: No change in review determination.</p> <p>DMS Response: DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Recommendation for DMS</u> Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The MCOs are responsible for ongoing care coordination for these members including assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the</p>	<ul style="list-style-type: none"> ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	
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.		Minimal	<p>Addressed in P/P CM 017 and CM 011.</p> <p><u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services.</p> <p>Coventry Cares should continue to work</p>	<p>MCO Response: The Prior Authorization Request Form has been updated to request the actual IEP form. (Enclosed)</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, Coventry Cares requested</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p> <p>Recommendation for DMS Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The MCOs are responsible for ongoing care coordination for these members including</p>	<p>DCBS schedule monthly meetings to discuss and sign off on service plans.</p> <p>See revised CM-011 and CM-017. (Enclosed)</p> <p>IPRO Comments: No change in review determination.</p> <p>DMS Response: DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.</p>	
32.9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse		Full	Addressed in the Provider Manual.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
examination. This examination must be conducted for Members at the request of the DCBS.				
32.8 Pediatric Interface				
The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except 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. IEP services should not be duplicated.		Substantial	Addressed in P/P CM 017 although not explicit regarding coverage during interruptions. <u>Recommendation for Coventry Cares</u> P/P CM 017 should be revised to address coverage during interruptions.	MCO Response: None
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, 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. Coordination		Substantial	Addressed in P/P CM 017 although not explicit regarding coverage/responsibilities during interruptions. <u>Recommendation for Coventry Cares</u> P/P CM 017 should be revised to address coverage during interruptions.	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.				
The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.		Full	Addressed in P/P CM 017.	
In order for Contractor and its Providers to effectively manage care for Members who qualify for these services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.		Substantial	Addressed in P/P CM 017 although does not explicitly address parental permission. <u>Recommendation for Coventry Cares</u> P/P CM 017 should be revised to address parental permission.	MCO Response: None
Services provided under HANDS shall be excluded from Contractor coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting		NA	DMS responsibility.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Case Management/Care Coordination <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
skills.				
37.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.		Full	Quarterly reports provided: Report 32, Enrollment Summary; Report 65, Foster Care Report; and Report 66, Guardianship Report.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	20	3	4	3
Total Points	60	6	4	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		70/30=2.33		

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 and early intervention services
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and satisfaction data 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 satisfaction with care 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

Number of DCBS and DAIL clients enrolled in the MCO as of the last day of the review period (December 31, 2012)

Number of DCBS and DAIL clients enrolled in the MCO who are enrolled in case management/care coordination as of the last day of the review period (December 31, 2012))



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Monthly reports of Foster Care cases

File Review

Care Coordination files for a random sample of cases selected by EQRO

Logs of DCBS/MCO and DAIL/MCO meetings to review members

DCBS and DAIL Service Plans for a sample of cases selected by EQRO

DCBS Case Management files/claims records



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.		Full	Member Rights and Responsibilities are addressed in Member Handbook. The Member Handbook is sent to each new member in the "Welcome Packet". The Member Handbook is updated annually, however if deemed necessary during the year "stickers" are sent to all members for insertion into the handbook detailing updates and changes to member issues, policies, etc. P/P RR-002, Member Right and Responsibilities, addresses this requirement.	
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.		Substantial	During the on-site visit, the MCO advised that the member's rights and responsibilities are located on the Website and are accessible to all out-of-network providers. <u>Recommendation for Coventry Cares</u> The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
C. Consent for or refusal of treatment and active participation in decision choices;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
F. Timely access to care that does not have any communication or physical access barriers;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
I. Timely referral and access to medically indicated specialty care; and		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
B. Abide by the Contractor's and Department's policies and procedures;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
C. Become informed about service and treatment options;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
D. Actively participate in personal health and care decisions, practice healthy life styles;		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
E. Report suspected Fraud and Abuse; and		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
F. Keep appointments or call to cancel.		Full	Member Rights and Responsibilities are addressed in Member Handbook. P/P RR-002 addresses this requirement.	
22.2 Member Handbook				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.		Full	P/P MC-004, Member Handbook addresses this requirement. The Member Handbook is sent to each new member in the "Welcome Packet". The Member Handbook is updated annually, however if deemed necessary during the year "stickers" are sent to all members for insertion into the handbook detailing updates and changes to member issues, policies, etc.	
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.		Full	P/P MC-004 addresses this requirement.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.		Full	P/P MC-004 addresses this requirement.	
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.		Full	P/P MC-004 addresses this requirement.	
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:		Full	P/P MC-004 addresses this requirement.	
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may		Full	Primary Care Provider Network is addressed in the Member Handbook. P/P MC-004 addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
be combined with the Member Handbook or distributed as a stand-alone document;			The MCO advised during the on-site visit that the provider directory is part of the welcome kit provided to new members and it is updated annually.	
B. The procedures for selecting a PCP and scheduling an initial health appointment;		Full	Primary Care Provider Network is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;		Full	Contractor information and hours of business are addressed in the Member Handbook. P/P MC-004 addresses this requirement.	
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;		Full	All available Covered Services are addressed in the Member Handbook. P/P MC-004 addresses this requirement.	
E. Member rights and responsibilities including reporting suspected fraud and abuse;		Full	Fraud and abuse is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;		Full	Emergency care and non-emergency after hours care are addressed in Member Handbook. P/P MC-004 addresses this requirement.	
G. Procedures for obtaining transportation for both emergency and non-emergency situations;		Full	Transportation is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
H. Information on the availability of maternity, family		Full	Direct access services are addressed in	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
planning and sexually transmitted disease services and methods of accessing those services;			Member Handbook. P/P MC-004 addresses this requirement.	
I. Procedures for arranging EPSDT for persons under the age of 21 years;		Full	EPSDT is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
J. Procedures for obtaining access to Long Term Care Services;		Full	Long Term Care services are addressed in Member Handbook. P/P MC-004 addresses this requirement.	
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;		Full	Notifying the Department for Community Based Services (DCBS) regarding member family size changes is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
L. A list of direct access services that may be accessed without the authorization of a PCP;		Full	Direct access services are addressed in Member Handbook. P/P MC-004 addresses this requirement.	
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;		Full	Selecting a PCP or requesting a change of PCP is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
N. Information about how to access care before a PCP is assigned or chosen;		Full	Access to a PCP before assignment is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;		Full	Second opinion is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
P. Procedures for obtaining Covered Services from non-network providers;		Full	Access to non-participating providers is addressed in Member Handbook. P/P MC-004 addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;		Full	Filing a grievance or appeal is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;		Full	Cabinet for Health and Family Services' independent ombudsman program is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;		Full	Behavioral health/substance abuse health services are addressed in Member Handbook. P/P MC-004 addresses this requirement.	
T. Information on the availability of health education services;		Full	Health education services are addressed in Member Handbook. P/P MC-004 addresses this requirement.	
U. Information deemed mandatory by the Department; and		Full	P/P MC-004 addresses this requirement.	
V. The availability of care coordination, case management and disease management provided by the Contractor.		Full	Case management and disease management are addressed in Member Handbook. P/P MC-004 addresses this requirement.	
30.3 Second Opinions				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request for		Full	P/P MC-004 and P/P UM-014, Second Opinion, address this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
a second opinion.				
22.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Standard Time (EST). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.		Full	P/P CSO-004, Call Center Standards addresses all the requirements as follows: Member and Provider Services will be open during the following hours of operation: Monday - Friday 6:00 a.m. - 6:00 p.m. CST.	
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).		Full	P/P UM – 029, 24 Hour Nurse Line, addresses this requirement. The 24-hour Nurse Line provides clinical triage, afterhours pre-authorization and health information services.	
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.		Full	During the on-site visit, evidence of monthly Call Center reports was provided for review.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.		Full	P/P MC – 006, Translation and Interpreter Services addresses the requirements. Language assistance for Customer Service calls to Member Services (CSO) is available and provided through the Language Line. When available, a member will be transferred to a bi-lingual associate. Hearing impaired members may use the TDD/TYY 711 option.	
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.		Full	Addressed in the Provider Manual: <ul style="list-style-type: none"> • The purpose of the American Disabilities Act is to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life. The Act also provides enforceable standards addressing discrimination against individuals with disabilities and ensures that the federal government plays a central role in enforcing these standards on behalf of individuals with disabilities. Addressed in the Member Handbook:	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>The Cabinet for Health and Family Services Ombudsman Program.</p> <ul style="list-style-type: none"> The Ombudsman Program helps citizens who use various public services to be treated fairly. The Office of the Ombudsman answers questions, looks into grievances and works to settle them. 	
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;		Non-Compliance	<p>Coventry Cares did not provide a policy and procedure for Member Services Functions. The MCO advised that the functions are listed in the training manual.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>MCO Response: New Policy MC-016 Member Services Functions has been drafted. (Enclosed) It will be reviewed and approved by the Policies & Procedures Committee.</p> <p>IPRO Comments: No change in review determination.</p>
B. Monitoring the selection and assignment process of PCPs;		Non-Compliance	See above.	<p>MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee.</p> <p>IPRO Comments: No change in review</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				determination.
C. Identifying, investigating, and resolving Member Grievances about health care services;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. I PRO Comments: No change in review determination.
D. Assisting Members with filing formal Appeals regarding plan determinations;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. I PRO Comments: No change in review determination.
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. I PRO Comments: No change in review determination.
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. I PRO Comments: No change in review determination.
G. Explaining Contractor's rights and responsibilities,		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;				Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
I. Explaining or answering any questions regarding the Member Handbook;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;				
K. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
M. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				determination.
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
O. Facilitating access to behavioral health services and pharmaceutical services;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
P. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
Q. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

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refer such problems to the designated Member Services Director for resolution;				IPRO Comments: No change in review determination.
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
S. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
T. Facilitating access to Member Health Education Programs;		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in Covered Services upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
V. The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.		Non-Compliance	See above.	MCO Response: New Policy MC-016 Member Services Functions has been drafted. It will be reviewed and approved by the Policies & Procedures Committee. IPRO Comments: No change in review determination.
30.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.		Full	Addressed in Provider Manual. During the on-site review, the MCO advised that the Provider Manual is included as part of the Provider Contract.	
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.		Full	Addressed in Provider Manual - Balance Bill/Hold Harmless.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
22.9 Choice of Providers				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.		Full	The Department of Community Based Services (DCBS) sends PCP assignments to Coventry Cares for the Foster Care population. This population is not part of the auto assignment process. Members identified as presumptive eligibility do not require a PCP.	
The Contractor shall have two processes in place for Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.		Full	Choosing a PCP is addressed in Member Handbook. P/P MC-004 addresses this requirement.	
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.		Full	P/P GA – 006, PCP Assignments and the Provider Manual addresses this requirement.	
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.		Full	P/P GA – 006, PCP Assignments and the Provider Manual addresses this requirement.	
A member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual		Full	P/P GA – 006 and the Provider Manual addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.				
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.		Full	P/P GA – 006 and the Provider Manual addresses this requirement.	
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.		Full	P/P GA – 006 and the Provider Manual addresses this requirement.	
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.		Full	Provider Manual addresses this requirement.	
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal		Full	Provider Manual addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
issues. The Member has the right to Appeal such a transfer in the formal Appeals process. The Provider shall make the change for request in writing. Member may request PCP change in writing, face to face or via telephone.				
The Contractor shall provide written notice within fifteen (15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the Contractor's network.		Full	P/P GA – 008, Primary Care Physician Termination addresses this requirement.	
30.5 Referral for Non-covered Contractor Services				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the contract, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Member for Non-Covered services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.		Full	<p>P/P UM – 048, Referrals for Non-Covered Services addresses the requirements as follows:</p> <ul style="list-style-type: none"> • Members who need services that are outside of the scope of the Coventry Cares of Kentucky contract will be referred to a qualified health care provider enrolled in the Medicaid fee-for-service program. • Non-Participating Provider Referral Request – Coventry Cares allows members to receive medically necessary services and treatment by a non-participating provider when the expertise necessary to support the best outcome is not available within the network. <p>Requests to refer the member out-of-network must have pre-authorization from</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Coventry Cares before services are to be rendered, except for the following: <ul style="list-style-type: none"> • Emergency services • Family planning • HIV screenings • TB screening. 	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	63	1	0	22
Total Points	189	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		191/86=2.22		

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



KY EQRO ANNUAL REVIEW March 2013

Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Enrollee Rights and Protection: Enrollee Rights Suggested Evidence

Documents

Policies/Procedures for:

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

Member Handbook including any separate inserts or materials

Sample Member newsletters and other informational materials

Sample Provider newsletters and other informational materials

Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers

Sample of member notifications of voluntary and involuntary PCP termination

Evidence of provision of Member Handbook within five business days of notification of enrollment

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county

Annual Member Services Report

Call center metrics

Medical call-in system metrics



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.		Full	<p>Marketing and Communications Plan 2011-2012 addresses all requirements.</p> <p>Coventry has eight dedicated outreach counselors (one for each region) who work within the communities to support the homeless and members who are victims of domestic violence to educate them on the availability of Medicaid and wellness programs.</p> <p>During the on-site review, the MCO provided a sample of the monthly monitoring report that is presented to Senior Executive staff during "score card" meetings held monthly.</p> <p>The MCO is looking to change to a more efficient reporting system called "Salesforce" in 2013.</p>	
Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach 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	Marketing and Communications Plan 2011-2012 addresses all requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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

State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.		Full	Marketing and Communications Plan 2011-2012 addresses all requirements. During the on-site, the MCO provided a sample of the monthly monitoring report that is presented to Senior Executive staff during "Score Card" meetings held monthly.	
22.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population within the Contractor's Region and by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.		Full	P/P M – 020, Homeless Policy, Homeless Outreach Plan and Kentucky Homeless Outreach address this requirement.	
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.		Full	P/P M – 020, Homeless Policy, Homeless Outreach Plan and Kentucky Homeless Outreach addresses this requirement.	
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	P/P M – 020, Homeless Policy, Homeless Outreach Plan and Kentucky Homeless Outreach address this requirement.	
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	P/P MC – 002, Communication Barriers Interventions for Members addresses all requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
be published in at least a 14-point font size, and		Full	P/P MC-001, Member Written Communication Standards addresses all requirements.	
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).		Full	P/P MC – 005, Requests for Alternative Format Member Materials addresses all requirements.	
Font size requirements shall not apply to Member Identification Cards.		Full	P/P MC-001, Member Written Communication Standards addresses all requirements.	
Braille and audiotapes shall be available for the partially blind and blind.		Full	P/P MC – 005, Requests for Alternative Format Member Materials addresses all requirements.	
Provisions to review written materials for the illiterate shall be available.		Full	P/P MC – 002, Communication Barriers Interventions for Members addresses all requirements.	
Telecommunication devices for the deaf shall be available.		Full	P/P MC – 002, Communication Barriers Interventions for Members addresses this requirement. P/P MC – 006, Translation and Interpreter Services addresses this requirement.	
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.		Full	P/P MC – 002, Communication Barriers Interventions for Members addresses this requirement. P/P MC – 006, Translation and Interpreter Services addresses this requirement.	
Materials shall be updated as necessary to maintain		Full	Marketing and Communications Plan	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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
accuracy, particularly with regard to the list of participating providers.			addresses all requirements.	
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	Marketing and Communications Plan addresses this requirement. P/P MC-001, Communication Standards addresses this requirement.	
28.12 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.		Full	Marketing and Communications Plan addresses this requirement. Provider Manual addresses this requirement. MC – 002, Communication Barriers Interventions for Members addresses this requirement. MC – 006, Translation and Interpreter Services addresses this requirement. Coventry teamed up with the Hispanic Coalition in Lexington (Region 2 and 4). A bi-lingual Social Worker is dedicated to these regions.	
The Contractor shall communicate such policies to Subcontractors.		Full	Provider Manual addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Enrollee Rights and Protection: Member Education and Outreach <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			P/P MC – 006, Translation and Interpreter Services addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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	18	0	0	0
Total Points	54	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	54/18=3			

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

Member and Community Education Outreach Plan

Outreach plan for homeless persons

Member Handbook

Member informational materials

Policies/procedures for promoting delivery of services in a culturally competent manner and evidence of communicating these policies/procedures to subcontractors

Reports

Reports of outreach activities



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	<p>The MCO's Quality Improvement department conducted the annual medical record audit in November 2012. Thirty charts were reviewed at 10 PCP offices (3 records per office). The results of the audit were presented to the QMUM committee meeting.</p> <p>The results demonstrated that two areas (BMI and Advanced Directives) fell below the medial record compliance standards. The MCO contracted all providers to re-educate them on the areas that fell below the 80% score through Fax Blasts. The Fax Blasts stated the following: <i>"A medical record review was conducted in November of 2012. During this review two areas of deficiencies were noted related to Body Mass Index (BMI), and Advanced Directives (AD). Please refer to the medical record review guidelines below regarding what is required for each chart"</i>.</p> <p>Coventry Care advised that the next medical record audit will review Specialists in addition to PCPs.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	<p>P/Ps Privacy – 001, Privacy and Security Compliance Program, UM – 031, Clinical Record Confidentiality and RR – 002, Member Rights and Responsibilities address this requirement.</p> <p>The following contracts address this requirement:</p> <ul style="list-style-type: none"> • Hospital contract - Section 6.3 Confidentiality • Provider Contract - Section 5.3 Confidentiality • Ancillary Contract - Section 9 Medical Records. 	
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.		Full	P/P HIPAA – 007, Accounting of Disclosure addresses this requirement.	
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The		Substantial	<p>P/P UM – 031 Clinical Record Confidentiality addresses confidentiality.</p> <p>The following contracts address this requirement: VSP- Section 7.5 Medical Records Access to Records – Section 7.6 Inspection and Audits of Records Section 7.4</p> <p>Medco - Section 9 Pharmacy Records Transition Period Records – Section 6</p>	MCO Response: None



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.			<p>Avesis-Section 9 Medical Records Transfer of Medical Records Access to Records and Audits, Number 4</p> <p>ASH-Section 2.18 & Section 9 Business Associate Agreement – Number 8</p> <p>NIA-Medical Records Section 7 Access to Records, Section 8</p> <p>MHNet-Access to Medical Records - Section IV Access to Medical Records for Inspection – Section IV Access to Records Transfer of Records – Article III, Section 3.3.</p> <p>Recommendation for Coventry Cares The contracts should include a provision for when a member changes PCPs, e.g., the medical records or copies of medical records shall be forwarded to the new PCP within ten (10) Days from receipt of request and the Contractor's PCPs shall have members sign a release of medical records before a medical record transfer occurs.</p>	
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		Full	P/P QI – 015, Medical Record Documentation Review addressed this requirement. Coventry also provided the Medical Record Report as evidence of this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.				
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:		Full	<p>P/P QI – 015, Medical Record Documentation Review addressed this requirement.</p> <p>The MCO's Quality Improvement department conducted the annual medical record audit in November 2012. Thirty charts were reviewed at 10 PCP offices. The results of the audit were presented to the QMUM committee meeting.</p> <p>Coventry also provided the Medical Record Report as evidence for this requirement</p>	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;		Full	<p>The MCO's Medical Record Report addressed this requirement as follows: 90% of the practices received a passing score of 80% or above.</p> <p>There was a trend identified with BMI and Advanced Directive documentation.</p> <p>The MCO noted that 70% of the practices use electronic medical records.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
B. Allow for the tracking and trending of individual and plan wide provider performance over time;		Full	<p>Coventry Care's Medical Record Report addresses this requirement.</p> <p>The MCO's Medical Record Report states for an initial audit, the focus was condensed to the closest regions to the Louisville Metro area; Region 4 and Region 5. The MCO reported that subsequent audits will address all 8 regions of the Commonwealth.</p>	
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and		Full	<p>The MCO's Medical Record Report addressed this requirement.</p> <p>The scores for documentation of BMI and Advanced Directives were below standards. Standard 11 for BMI received an overall score of 70.03% and Standard 20 for Advanced Directives received an overall score of 53.38%.</p> <p>The MCO contracted all providers to re-educate them on the areas that fell below the 80% score through Fax Blasts. Both members and providers receive information on Advanced Directives. Information on Advanced Directives is mailed to new enrollees with their enrollment information.</p>	
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.		Non-Compliance	Evidence of a process for detecting instances of over-utilization, under-utilization, and miss utilization was not provided.	MCO Response: Please see policy UM-017 enclosed and the Program Integrity Plan. Both documents address monitoring over and under utilization of services.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>IPRO Comments: No change in review determination.</p>
27.6 Medical Records				
<p>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.</p>		Full	<p>The following contracts address this requirement:</p> <ul style="list-style-type: none"> • Hospital contract - Section 9 Medical Records • Provider Contract - Section 9 Medical Records • Ancillary Contract - Section 9 Medical Records. 	
The Member's Medical Record is the		Full	The Member Handbook and Provider	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).			Handbook address this requirement. The MCO's policy for Record Retention also addresses this requirement. Coventry Cares provided the Record Retention Chart – Kentucky 2013 which details the types of documents retained and the length of the retention period.	
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	P/P QI-015, Medical Record Documentation Review and the Provider Manual address this requirement. The MCO's Medical Record Report addresses this requirement.	
A. Member/patient identification information, on each page;		Full	The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements. The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The medical record documentation audit tool includes this requirement.	
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	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
C. Date of data entry and date of encounter;		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
D. Provider identification by name;		Full	The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The medical record documentation audit tool includes this requirement.	
G. Identification of current problems;		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
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	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
I. Documentation of immunizations pursuant to 902 KAR 2:060;		Full	The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
J. Identification and history of nicotine, alcohol use or substance abuse;		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
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	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The medical record documentation audit tool includes this requirement.	
L. Follow-up visits provided secondary to reports of emergency room care;		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
M. Hospital discharge summaries;		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
N. Advanced Medical Directives, for adults;		Full	The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
O. All written denials of service and the reason for the denial; and		Full	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
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	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p>	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The medical record documentation audit tool includes this requirement.	
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;		Substantial	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool states "identification of current problems, significant illnesses, and medical/psychological condition should be indicated on the Problem List/or progress note." Physical examination is not included in the tool.</p> <p>Recommendation for Coventry Cares Audit tool for medical record documentation should include all required elements.</p>	MCO Response: None
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed		Full	The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
from previous visits; and			<p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes this requirement.</p>	
<p>C. Plan of treatment including:</p> <ol style="list-style-type: none"> 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. 		Substantial	<p>The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen. Follow-up plans are addressed.</p> <p><u>Recommendation for Coventry Cares</u> Audit tool for medical record documentation should include all required elements.</p>	MCO Response: None
27.7 Advance Medical Directives				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.		Full	P/P RR – 001, Advanced Directives addresses this requirement. Member Handbook and Provider Manual address this requirement. The MCO provided a sample of the Advanced Directives Member Letter as evidence for this requirement.	
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	Member Handbook and Provider Manual address this requirement.	
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	Provider Manual addresses this requirement.	
38.2 Confidentiality of Records				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

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 parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.		Full	Coventry provided the following documents to address this requirement: <ul style="list-style-type: none"> • Privacy – 001 Privacy and Security Compliance Program • Privacy – 002 Minimum Necessary. P/P UM-031, Clinical Record Confidentiality also addresses this requirement.	
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.		Full	P/P UM – 037, Family Planning Services and Treatment of Sexually Transmitted Diseases addresses this requirement. The following P/Ps also address this requirement: Privacy – 001, Privacy and Security Compliance Program HIPAA – 009, Member's Right to Request Restrictions to Disclosure UM-031, Clinical Record Confidentiality.	
The Contractor on behalf of its employees, agents and assigns, shall sign		Full	The MCO advised the following: <i>The Business Associate Agreement is on file</i>	.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
a confidentiality agreement.			<i>with the Commonwealth of Kentucky. A signed copy of the confidentiality agreement has been requested and can be supplied once it has been received.</i>	
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.		Full	P/P HIPAA-003, Business Associates and P/P Privacy-002, Minimum Necessary address this requirement.	
40.12 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		Full	Coventry provided evidence of a signed confidentiality agreement on behalf of employees, agents and assigns. P/P HIPAA-003, Business Associates addresses this requirement. HIPAA-007, Accounting of Disclosures addresses this requirement.	



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as is the Contractor.				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	36	3	0	1
Total Points	108	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		114/40=2.85		

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares

Final Report 9.11.13

Medical Records
Suggested Evidence

Documents

Policies/procedures for:

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

Sample contracts between MCO and network providers and subcontractors demonstrating provisions for medical records and documentation standards; and confidentiality/HIPAA requirements

Member materials related to Advance Directives

Provider materials related to Advance Directives

Evidence of signed confidentiality agreement on behalf of employees, agents and assigns

Reports

Provider compliance assessment/monitoring results and follow-up



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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 mental 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	Addressed in Coventry and MHNet documents including: MHNet Provider Quick Reference Guide, MHNet member brochure, MHNet contract, Coventry Member Handbook and Provider Manual.	
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	Addressed in MHNet contract and UM Program Description.	
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-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV.		Full	Addressed in MHNet Network Development Manual and Provider Quick Reference Guide.	
Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.		Full	Addressed in MHNet Provider Quick Reference Guide.	
33.5 Behavioral Health Provider Network				
The Contractor must emphasize utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate		Full	MHNet UM Program Description addresses reporting. Geo Access reports and Report 107, Behavioral Health Network Capacity provided.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
on the requirement of data collection and reporting to assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.				
The Contractor shall utilize DSM-IV classification for Behavioral Health billings.		Full	Addressed in MHNet Provider Quick Reference Guide.	
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.		Full	Addressed in MHNet Network Development policy. Demonstrated in Geo Access reports.	
In order to meet the provider network requirement for BH services, Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.		Substantial	<p>Demonstrated in Geo Access reports.</p> <p>Coventry Cares provided Geo Access reports for July 2012 for Community Mental Health Centers. All counties were compliant with the exception of: Region 5, Madison at 65.9% for urban Region 6, Gallatin and Grant at 66.2% and 86.2% for urban.</p> <p><u>Recommendation for Coventry Cares</u></p> <p>The above counties did not meet access standards. This may be due to the number of CMHCs available for contracting in those counties. The MCO should clarify whether all CMHCs in the region were offered participation and whether all accepted participation.</p>	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.		Full	Addressed in MHNet Network Development policy. The MCO reported that out-of-state placements have been reduced from a high of 200+ to 4 currently.	
The Contractor shall ensure accessibility and availability of qualified providers to all Members in the service area pursuant to Provider Program Capacity Demonstration as contained in the RFP. When necessary to meet the access standards for Behavioral Health Services for its Members, the Contractor may include in its provider network other specialty care clinic providers with comparable core services of the CMHC's.		Minimal	Program capacity demonstrated in Geo Access reports. The MCO also provided a listing of credentialed behavioral health providers. Coventry Cares provided the MHNet Quality and Utilization Management Fourth Quarter Report dated 1/31/13 including monitoring results for provider appointment availability. The results presented include MHNet's national provider network; results for the individual Kentucky market are not available. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	MCO Response: MHNet is currently in compliance with this standard. MHNet has offered network participation to all CMHCs in KY and currently contracts with 100% of the CMHCs. Please see enclosed document for supporting information. I PRO Comments: No change in review determination.



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
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	Addressed in KY physician contract template and MHNet provider contract template.	
Since the Contractors shall offer participation agreements to the Community Mental Health Centers to participate in their Behavioral Health network, should a Community Mental Health Center decline participation in the Contractor in that service area, or if the Contractor fails to meet access or any other terms and conditions of the contract the Contractor may meet its BH network requirements by offering participation to other qualified specialty care clinic providers with comparable core CMHC services.		Full	Addressed in KY physician contract template and MHNet provider contract template.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.		Full	Addressed in Coventry Member Handbook, Coventry member website (screen shot provided), and MHNet member brochure.	
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	Addressed in Coventry Member Handbook, Coventry member website (screen shot provided), and MHNet member brochure.	
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis		Full	Addressed in MHNet Member Services	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Behavioral Health Services (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Behavioral Health Services 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.			Policy and Procedures 5 and Coventry Member Handbook.	
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.		Full	Addressed in MHNet Member Services Policy and Procedures 5.	
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	Addressed in MHNet Member Services Policy and Procedures 5 and Coventry Member Handbook.	
It is not acceptable for an intake line to be answered by an answering machine.		Full	Addressed in MHNet Member Services Policy and Procedures 5.	
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:		Full	Addressed in MHNet Member Services Policy and Procedures 5.	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;		Full	Addressed in MHNet Member Services Policy and Procedures 5. MHNet requires that calls are answered within 30 seconds of first ring. Call Center monthly reports demonstrate compliance with the state requirements.	
B. No incoming calls receive a busy signal;		Full	Call Center monthly reports demonstrate compliance.	
C. At least eighty percent (80%) of calls must be answered		Full	Call Center monthly reports	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;			demonstrate compliance.	
D. The call abandonment rate is seven percent (7%) or less;		Full	Call Center monthly reports demonstrate compliance.	
E. The average hold time is two (2) minutes or less; and		Full	Call Center monthly reports demonstrate compliance.	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.		Full	Addressed in MHNet Member Services Manual and UM Manual.	
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.		Full	Addressed in MHNet Member Services Manual and UM Manual.	
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.		Minimal	<p>The document provided – Member Services Manual 5 does not address duration of calls. Other documents referenced – UM Manual 3.5 and Customer Service Monitoring Tool were not provided.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse</p>	<p>MCO Response: Both the Member Services Manual and the Utilization Management Policy & Procedures were updated to reflect MHNet's current policy that there is no call limit. We have never had a limitation on call duration. Please see enclosed documentation.</p> <p>IPRO Comments: No change in review determination.</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
			quality finding or deficiency identified by the EQRO.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.		Full	Addressed in Member Services Manual 7.	
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.		Full	The Crisis Call Training module includes referrals to service area services.	
The Contractor shall conduct on-going quality assurance to ensure these standards are met.		Full	The Service Centers, as described in Member Services Manual 5, are responsible for data collection, identification of improvements, interventions and reporting.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.		Full	Call Center reports provided.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.		NA	DMS responsibility.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
33.7 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.		Full	Addressed in the Coventry Provider Manual and KY physician contract template.	
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.		Substantial	The Provider Orientation Education policy and procedure, and Provider Orientation Presentation provided do not explicitly address screening and identification of behavioral health disorders. <u>Recommendation for Coventry Cares</u> Provider training should address screening and identification of behavioral health disorders.	MCO Response: None
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	Addressed in the MHNNet UM Manual and Provider Quick Reference Guide. <u>Recommendation for DMS</u> It is suggested that future annual compliance reviews include a behavioral health/physical health file review to assess coordination of physical health	DMS Response: DMS agrees with IPRO's recommendation. Appropriate files will be requested from each MCO for the next compliance review.



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
			and behavioral health services, and compliance with behavioral health standards.	
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	Addressed in the MHNet Provider Quick Reference Guide.	
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	Addressed in the MHNet Provider Quick Reference Guide.	
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.		Full	Addressed in the MHNet Provider Quick Reference Guide.	
The outpatient treatment must occur within fourteen (14) days from the date of discharge.		Full	Addressed in the MHNet Provider Quick Reference Guide.	
The Contractor shall ensure that Behavioral Health		Minimal	The MHNet UM Manual 6 indicates that	MCO Response: This is documented in



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Behavioral Health Services <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.			<p>case managers will contact members who have missed appointments, however a timeframe for doing so is not included in the policy.</p> <p>Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p>	<p>the attached Provider Contract (Section 27) and the Provider Addendum. We have modified the Provider Quick Reference Guide to reflect this. See enclosed documents.</p> <p>IPRO Comments: No change in review determination.</p>
33.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to 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	Addressed in the MHNet Provider Quick Reference Guide.	
The Contractor cannot deny, reduce or controvert the		Substantial	The Provider Quick Reference Guide	MCO Response: None



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
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.			does not address modification or termination of services. <u>Recommendation for Coventry Cares</u> Policy should be expanded to include modification or termination of services.	
33.10 Community Mental Health Center (CMHC)				
The Contractor shall coordinate with the Community Mental Health Center (CMHC) or other qualified special health care providers, other providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric hospital.		Full	CMHC contract provided.	
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.		Full	MHNet Facility Provider Contract addresses requirement.	
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	Coventry response: DBH/DID holds quarterly care coordination meetings with the MCOs. The agendas include member names and distribution is	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
			controlled by DBH/DID.	
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide case management services to Members with severe mental illness and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.		Full	Addressed in MHNet Policy and Procedure 6.	
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	Addressed in MHNet Policy and Procedure 6.	
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	Addressed in MHNet Policy and Procedure 6 and MHNet Provider Quick Reference Guide.	
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	Coventry response: Medicaid members are not candidates for manufacturers patient support programs due to best price considerations.	
33.11 Program and Standards				



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);		Full	Addressed in various Coventry and MHNNet documents and reports including: MHNNet - Provider Quick Reference Guide, UM Program Description, QI Program Description, UM Manual, Member Brochure and provider contract template; Coventry – GeoAccess reports, Member Handbook and member website.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;		Minimal	Documents provided discuss coordination of care and sharing of information. MHNNet Provider Quick Reference Guide references coordination of medication usage. Documents for non-behavioral health providers, such as the Provider Manual and physician contract do not specifically address sharing of medication usage information. Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan	MCO Response: MHNNet has a process in place to address polypharmacy issues through the pharmacy department. MHNNet facilitates coordination of information between PCPs and Behavioral health Providers. Please see enclosed documentation. MHNNet facilitates communication between Primary Care Physicians and Behavioral Health Providers. Members are requested to give permission for MHNNet to provide copies of their outpatient treatment plan request (OTR) to their primary care physician. The OTR is submitted by the behavioral health



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
			to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	<p>provider to request additional authorization for treatment. It includes current diagnosis, clinical information, risk factors and medications. This treatment plan is usually received and forwarded by MHNet every three to six months. Behavioral health providers and primary care physicians are encouraged to communicate in addition to this program to ensure members' needs are met.</p> <p>Members receive the consent form to allow MHNet to send clinical information to their PCP at the time they first access services in the member brochure. There continues to be the barrier that members may be hesitant to share behavioral health information with their PCP. MHNet in partnership with the health plans will educate members and providers about the importance and positive outcomes of coordinated care.</p> <p>MHNet routinely completes treatment record review to ensure that quality care is being provided to members and documented. As part of this process MHNet monitors to ensure that behavioral health and primary care providers are communicating to provide</p>



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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
				coordinated services to the member. IPRO Comments: No change in review determination.
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	MHNet medical record reviews for record keeping practices (prior to credentialing) and treatment record reviews (recredentialing) include evaluation for continuity and coordination of care.	
D. Protect the confidentiality of Member information and records; and		Full	Confidentiality of member information is addressed in provider manuals, HIPAA policies, business associate agreements, and member materials such as the Member Handbook.	
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.		Full	Addressed in MHNet QI Program Description and QI Work Plan.	
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.		NA	DMS responsibility.	



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	46	3	4	0
Total Points	138	6	4	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		148/53=2.79		

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



KY EQRO ANNUAL REVIEW

March 2013

Period of Review: November 1, 2011 – December 31, 2012

MCO: Coventry Cares

Final Report 9.11.13

Behavioral Health Services

Suggested Evidence

Documents

Policies/procedures for:

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

Benefit Summary (covered/non-covered BH services)

Provider Manual

Sample PCP contract

Sample BH provider contract

Process for educating members of where and how to obtain BH services

Process for monitoring compliance with hotline requirements

Process for educating PCPs of BH services/requirements

Evidence of training of PCPs regarding BH services/requirements

Sample participation agreement with CMHCs

Sample collaborative agreement with state operated or state contracted psychiatric hospitals

Process for coordination of services for members committed by court of law to the state psychiatric hospital

Guidelines/procedures ensuring accessibility, availability, referral and triage including emergency BH services

Process for facilitating the exchange of pharmaceutical information among providers

Process for evaluating continuity and coordination of care among providers

QI Plan



**KY EQRO ANNUAL REVIEW
March 2013**

**Period of Review: November 1, 2011 – December 31, 2012
MCO: Coventry Cares**

Final Report 9.11.13

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Final Report 9.11.13

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
31.1 Pharmacy Requirements				
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;		Full	Addressed in Integrated Prescription Drug Program Master Agreement.	MCO Response: CoventryCares of Kentucky is fully compliant.
B. Retrospective utilization review services;		Full	Addressed in Integrated Prescription Drug Program Master Agreement, Drug Utilization Review Report, and Kentucky Pharmacy Referrals report.	MCO Response: CoventryCares of Kentucky is fully compliant.
C. Formulary and non-formulary services, including prior authorization services;		Full	Drug formulary provided. Addressed in P/P PHM - 002 Criteria for the Formulary, and MCO Reports 59 (Prior Authorizations) and 39 (Monthly Formulary Management).	MCO Response: CoventryCares of Kentucky is fully compliant.
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere; and		Full	Addressed in Integrated Prescription Drug Program Master Agreement.	MCO Response: CoventryCares of Kentucky is fully compliant.
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors.		Full	Addressed in Integrated Prescription Drug Program Master Agreement, P/P GEN-004 Attachments A and B Encounter Data Submission, and Attachment C Attestation.	MCO Response: CoventryCares of Kentucky is fully compliant.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Final Report 9.11.13

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
31.2 Formulary and Non-Formulary Services				
<p>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.</p>		Full	<p>Addressed in Drug Formulary and P/P PHM-002, Criteria for the Formulary.</p> <p>Addressed in the Member Handbook, 2012-13 Global Choice Schedule of Benefits, 2012-13 Family Choices Schedule of Benefits, and the following policies:</p> <p>PHM - 007 Early Refill v.2</p> <p>PHM - 006 Drug Recall v.2</p> <p>PHM - 005 Prior Authorization for Step Drug</p> <p>PHM - 004 Off Label Medication Utilization</p> <p>PHM - 003 Non-Formulary</p> <p>PHM - 001 Quantity Limit Exceptions.</p> <p><u>MCO Report #39</u> For the time period of November 2011-November 2012, CoventryCares reported 5,271,480 prescriptions including 2,036,916 new prescriptions and 3,234,564 refills. There were 279,426 non-PDL prescriptions and 45,086 prior authorizations (PA)</p>	<p>MCO Response: CoventryCares of Kentucky is fully compliant.</p>



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Final Report 9.11.13

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			requested of which 32.9% of PAs were denied. From the data provided it is unclear as to how many PAs were for step therapy, clinical issues or straight non-formulary items. It is unclear as to the outcome of the non-PDL requests for which PA was not obtained.	
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The committee shall meet periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary.		Full	CoventryCares provided the Pharmacy and Therapeutics (P&T) Committee Charter. Minutes for the National Medicaid P&T Committee and the CoventryCares of KY Medicaid P&T Committee were provided.	MCO Response: CoventryCares of Kentucky is fully compliant.
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members. 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	Addressed in the Provider Manual.	MCO Response: CoventryCares of Kentucky is fully compliant.
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	Addressed in the Integrated Prescription Drug Program Master Agreement.	MCO Response: CoventryCares of Kentucky is fully compliant.
The Contractor maintains, through an online system,		Full	Addressed in the Integrated	MCO Response: CoventryCares of



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Final Report 9.11.13

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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.			Prescription Drug Program Master Agreement and the Integrated Prescription Drug Program Master Agreement - First amendment.	Kentucky is fully compliant.
The Contractor shall interface with the Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.		Full	Addressed in the Integrated Prescription Drug Program Master Agreement and the Integrated Prescription Drug Program Master Agreement - First amendment.	MCO Response: CoventryCares of Kentucky is fully compliant.
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	[RXR-1] Rx Rebate Receivable addressed this requirement.	MCO Response: CoventryCares of Kentucky is fully compliant.
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization Review (Pro-DUR) at the POS. They also provide Retrospective		Full	Drug Utilization Reports were provided for quarters 1-3.	MCO Response: CoventryCares of Kentucky is fully compliant.



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Final Report 9.11.13

Pharmacy Benefits <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.				



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	13	0	0	0
Total Points	39	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	39/13=3			

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



KY EQRO ANNUAL REVIEW
March 2013
Period of Review: November 1, 2011 – December 31, 2012
MCO: CoventryCares of Kentucky

Final Report 9.11.13

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

Retrospective Drug UR reports