



**KY EQRO ANNUAL REVIEW  
MARCH 2013  
Period of Review: July 1, 2011-December 31, 2012  
PASSPORT HEALTH PLAN**

**Final Report 9.11.13**

<b>Quality Assessment and Performance Improvement: Measurement and Improvement</b> <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from 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><u>5.0 Quality Improvement</u></b> The Contractor's QAPI program must conform to requirements of 42 CFR 438, Subpart D.				
<b>5.1 QAPI Program</b>				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.		Full	PHP's 2012 Quality Improvement (QI) Program Description outlines the plan's comprehensive program that addresses clinical quality, member safety, member satisfaction, care coordination and access and services issues.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.		Full	The QI Program Description describes activities including evaluation of access (utilization including EPSDT, prospective practitioner site visits, access reports, member grievances), continuity of care (case management/disease management activities, medical record audits, member grievances), health care outcomes (HEDIS and Healthy Kentuckian measures, Clinical Practice Guideline audits, Performance Improvement Projects, monitoring of sentinel events and member grievances) and other plan services (delegation oversight activities, provider satisfaction, service measures).	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.		Full	PHP's QI processes include prospective, concurrent and retrospective quality	



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			improvement activities that are outlined in the QI Program Description, UM Program Description and Clinical Programs Program Descriptions; the QI structure is clearly defined in the Program Description.	
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><b><u>Recommendation for PHP</u></b> The plan should link EQR findings to QI program activities, and ensure that issues identified in annual reviews are included in Work Plans</p> <p><b><u>PHP Response:</u></b> The 2011 QI Program Evaluation was approved by the Quality Medical Management Committee, the Partnership Council, and the UHC Board in 1st quarter 2012, but will be updated with the EQRO's recommendations and resubmitted to the appropriate committees for approval. The 2012 QI Program Evaluation and 2012 work plan will be updated to include EQR findings related to QI program activities.</p> <p><b><u>IPRO Comments:</u></b> The plan will update documents to</p>	Substantial	<p>The QI Workplan was updated (p.57) to include EQR findings, and indicates how the issues that were identified were addressed.</p> <p><b><u>Recommendation for PHP</u></b> Include in the QI evaluation any system changes identified via the plan's PIPs. PIP reports should include a description of any system changes that were made and whether they were sustained.</p>	<p><b>MCO Response:</b> Passport accepts the recommendation and will update the 2012 QI Evaluation to include any system changes identified via Passport's PIPs. PHP will also update the 2013 PIP reports to include a description of any system changes that were made and denote mechanisms that ensure sustainability of success.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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	include EQR activities. No change in review determination.  <b>Substantial Compliance</b>			
The QAPI program shall be developed in collaboration with input from Members.		Full	The Quality Member Access Committee (QMAC) meets every two months.  The Partnership Council membership, as per the 2012 QI Program Description, includes consumer advocates or members, and consumer advocates are represented on the Quality Medical Management Committee (QMMC); these bodies approve the annual QI Program and Evaluation and QI Work Plans.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.		Full	QMAC bi-monthly reports provided. QMAC Committee minutes document evidence of member input; Committee minutes reveal review of QI Work Plans, discussion of Case and Disease Management Programs, discussion of care management for special needs populations, medical record audits, clinical practice guidelines, member concerns, and access and availability.	
The Contractor shall have and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid		Full	The plan has held NCQA accreditation with "Excellent" status for its Medicaid product line	



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product line.			from September 16, 2008-September 16, 2012. Reaccreditation will extend to September 30, 2014, with Excellent status.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.		Full	Copy of 2011 certification status provided, which extends to September 30, 2014.	
Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.		Full	An email dated 1/30/12 was sent by PHP to DMS.	
<b>5.2 Annual QAPI Review</b>				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes. The Contractor shall prepare a written	<b>Recommendation for PHP</b> EQR findings and corrective actions should be included in the QI Program Evaluation  The plan should consider including hospitalization and ED visit data in the program evaluation for populations with special needs	Full	EQRO recommendations and plan responses were included in the Annual QI Program Evaluation. PHP addressed several of the EQRO recommendations and indicated it is implementing interventions to address the recommendations. As an example, a section in the QI Evaluation is devoted to the recommendations made by the EQRO in the 2012 Compliance Review and includes how	



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<p>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 quality of 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 health care, provided to Members. The Contractor shall submit this report by July 31 of each contract year.</p>	<p><b>PHP Response:</b> Final findings of the annual review from July 2011 included the recommendation to incorporate the EQRO annual evaluation findings in the 2010 QI Program Evaluation and 2011 work plan. PHP agreed to include EQRO findings in the annual QI work plan and evaluation. Upon review of the Response to 2011 External Quality Review Technical Report Recommendations, it was noted that a statement regarding "Reviewing and responding to external quality review organization's recommendations" was added to the 2010 QI Program Evaluation. The EQRO annual evaluation findings were not incorporated in the 2010 QI Program Evaluation and 2011 work plan. The 2011 QI Program Evaluation and 2012 work plan will be updated with the EQRO's recommendations and resubmitted to the appropriate committees for approval.</p>		<p>PHP will address the recommendations. Also, PHP added an analysis of inpatient utilization by Category of Aid to the Program Evaluation.</p> <p>The QI Program Evaluation also assesses the effectiveness of the QI Program, and includes identification of barriers to improvement and changes to the program to be implemented, which are included in subsequent Work Plans.</p>	



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	<p>The plan will consider including hospitalization and ED visit data in the program evaluation for populations with special needs.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
<b>5.3 External Quality Review Organization</b>				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.		Full	<p>PHP provides information to the EQRO for mandatory and optional activities, including documentation for the annual review, performance measure reports, Performance Improvement Project (PIP) reports and samples for focused studies conducted by the EQRO.</p> <p>Documentation for the annual compliance review was provided to the EQRO by 2/28/12.</p>	
The Contractor shall assist the Department and the EQRO in completing all managed care organization reviews in accordance with protocols found as part of 42 CFR 438, Subpart E. These protocols guide the external, independent review of the quality outcomes and timeliness of, and access to, services provided by the Medicaid managed care		Full	<p>PHP assisted in the current compliance review by providing information for the annual review, PIP validation, performance measure validation, and encounter data validation, as well as focused studies; PHP staff members necessary to the review were made available</p>	



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organization.			by PHP.  HEDIS is audited by an independent, NCQA-Certified Licensed organization and the HEDIS Final Audit report was made available to the EQRO.	
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. This includes informing the Providers and subcontractors of the EQRO role and medical chart review.	<p><b><u>Recommendation for PHP</u></b> PHP should ensure that providers are aware of the role of the EQRO</p> <p><b><u>PHP Response:</u></b> The Plan will evaluate opportunities and implement interventions to increase provider's knowledge of the EQRO's role.</p> <p><b><u>IPRO Comments:</u></b> The plan will explore ways to disseminate role of EQRO to providers. No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>The Provider Manual (page 2), was updated to include reference to the role of the EQRO.</p> <p>A letter from PHP to its providers was provided as an example. The letter informed providers of an upcoming ADHD study to be conducted by DMS and IPRO and asked them to cooperate by providing medical records for data collection.</p>	
When the EQRO under contract with the Department identifies an adverse quality finding from their reviews that requires a follow up plan, the Contractor shall:				



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(a) Assign a staff person(s) to conduct follow-up concerning review findings;		Full	Several PHP staff are assigned to address review findings.  The 2012 QI Program Description identifies the Director of Quality Improvement as the person responsible for implementing the QI Program, which includes reviewing and responding to recommendations from the external review.	
(b) Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and	<p><b><u>Recommendation for PHP</u></b> EQR findings should be presented to quality committees and included in the QI Program Evaluation</p> <p><b><u>PHP Response:</u></b> The 2011 QI Program Evaluation will be updated with the EQRO's recommendations and resubmitted to the appropriate committees for approval. The EQRO findings will be presented to quality committees in 2012.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Non-Compliance</b></p>	Full	The 2011 Program Evaluation was updated to include the statement that "EQRO findings should be presented to quality committees and included in the QI Program Evaluation."	



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(c) Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.		Full	PHP submitted a timely response to review findings, including updating policies and implementation of new activities and procedures. Several documents were updated during the onsite review, as a result of the EQRO reviewer's recommendations.	
(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.	<p><b><u>Recommendation for PHP</u></b>            The plan should ensure that specific findings of concern, such as follow-up of member concerns, are incorporated into Quality Improvement activities and documented in the QI Program Evaluation and Work Plans</p> <p><b><u>PHP Response:</u></b>            The plan will ensure that specific findings of concern, such as follow-up of member concerns, are incorporated into Quality Improvement activities and documented in the QI Program Evaluation and Work Plans in 2012.</p> <p><b><u>IPRO Comments:</u></b>            No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>EQRO findings are included in the QI Program Description as an objective and in the Program Evaluation as the responsibility of the Quality Department.</p> <p>Monitoring of member complaints and grievances has been added to the 2012 Work Plan.</p>	



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(e) If contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department.		NA	No evidence of disagreement.	
(f) If initial finding is not overturned following appeal, contractor will comply with steps 1-5 referenced above.		Full	PHP has updated policies and implemented new activities and procedures in response to review findings.	
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.		NA	The DMS uses the results of EQR to monitor compliance with 42 CFR 438 and State regulations.	
<b>5.4 QAPI Plan</b>				
The Contractor shall have a written QAPI work plan that is approved by the governing boards and		Full	PHP provided the 2011 Work Plan, which is updated quarterly. The 2011 QI Program Evaluation was approved by the Quality Medical Management Committee, the Partnership Council, and the UHC Board in the 1 <sup>st</sup> quarter, 2012.	
outlines the scope of activities and		Full	The Work Plan outlines the scope of activities for each area of concentration organized by focus areas that include safety, member and provider satisfaction, delegation oversight, continuity and coordination, access and availability, credentialing, medical management, special populations and the	



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			quality improvement program.	
the goals,		Full	The Work Plans include program goals for the identified area of focus.	
objectives, and		Full	Objectives are included in each of the focus areas of the Work Plan.	
timelines for the QAPI program.	<p><b><u>Recommendation for PHP</u></b> The plan should consider specifying timeframes for implementation of activities and achievement of goals in the Work Plan</p> <p><b><u>PHP Response:</u></b> The plan will add timelines for implementation of activities and achievement of goals in the Work Plan.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Substantial	<p>Quality improvement activities are reported quarterly, and include time frames of completion of activities.</p> <p><b><u>Recommendation for PHP</u></b> Though activities are noted by Quarter in the Work Plan, the timeliness for implementing current and future activities is not included. PHP may want to consider including an annual "Executive Summary" in the Work Plan highlighting key milestones as well as the dates that the milestones were achieved.</p>	<p><b>MCO Response:</b> Passport Health Plan accepts the recommendation and will compile an annual "Executive Summary" of the 2012 Work Plan to highlight key milestones as well as the dates that the milestones were achieved. The "Executive Summary" will be submitted to the appropriate Quality committees for review and approval.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>
New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	<p><b><u>Recommendation for PHP</u></b> EQRO findings should be included in the Program Evaluation, and goals and objectives relevant to findings should be identified</p>	Full	Opportunities for improvement noted in the review of quality activities and studies are incorporated into goals in the Work Plans, which are updated quarterly; Work Plan goals and objectives are updated annually.	



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	<p><b><u>PHP Response:</u></b> Upon review of the Response to 2011 External Quality Review Technical Report Recommendations, it was noted that a statement regarding "Reviewing and responding to external quality review organization's recommendations" was added to the 2010 QI Program Evaluation. The EQRO annual evaluation findings were not incorporated in the 2010 QI Program Evaluation. The 2011 QI Program Evaluation was approved by the Quality Medical Management Committee, the Partnership Council, and the UHC Board in 1<sup>st</sup> quarter 2012, but will be updated with the EQRO's recommendations and resubmitted to the appropriate committees for approval. The EQRO findings will be presented to quality committees in 2012. Goals and objectives relevant to findings will be included.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p>		<p>In response to the prior year EQRO recommendation, recommendations were added to the Work Plan.</p>	



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	<b>Substantial Compliance</b>			
UHC's governing body is ultimately accountable to the Department for the quality of care provided to Members. Oversight responsibilities of this body include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;		Full	The UHC board is the governing body for the plan as noted in QI Program Description; UHC delegates ongoing oversight of deliverables for the QI and UM programs to the Partnership Council, and the Quality Medical Management Committee (QMMC) provides direction to and oversight of the provision of clinical care and services.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;		Full	UHC delegates ongoing oversight of deliverables for the QI and UM programs to the Partnership Council, and the QMMC provides direction to and oversight of the provision of clinical care and services.  The Chief Medical Officer provides day to day oversight of quality improvement and credentialing activities.	
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	Partnership Council minutes reflect review of the surveys, and case management and disease management programs, and review of QMMC committee minutes. The QMMC has been delegated the responsibility of review and	



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			approval of the annual QI and UM Program Descriptions and Evaluations, review of the QI Work Plan and review and feedback of audit findings and clinical and preventive health guidelines.	
formal review on an annual basis of the QAPI program; and		Full	The 2011 Annual QI Program Evaluation Report provides the infrastructure for the continuous monitoring, evaluation and improvement in care, safety, and service. The report includes a discussion of the network management activities, credentialing and recredentialing activities, clinical and service activities, and an overall assessment of effectiveness and opportunities for 2012.	
directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.		Full	The Partnership Council committee minutes reflect ongoing discussion of QI activities.  The QI Program Evaluation report monitors and analyzes key clinical and service indicators and intervention studies in clinical and service areas which were selected based on review of data.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program and that reports to the		Full	The QMMC is responsible for direction and oversight of clinical care and services, and reports every two months to the Partnership	



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governing bodies.			Council; it met 9 times in 2012 to meet QI program objectives. Committee minutes reflect robust participation and discussion of quality activities and results.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Members with disabilities.	<p><b><u>Recommendation for PHP</u></b> The Women's Health committee was apparently not convened during the review period; the plan should consider ways to ensure that Women's Health Issues, which were prominent during the review period, are addressed with the benefit of expert input</p> <p><b><u>PHP Response:</u></b> The Women's Health Committee is an ad hoc committee. The current structure is being reviewed by the Chief Medical Officer.</p> <p><b><u>I PRO Comments:</u></b> Committee structure is under review; review determination will not change.</p> <p><b>Substantial Compliance</b></p>	Full	<p>The QMMC includes provider and administrative staff members, as well as pharmacist, medical ethicist, member advocate and health department representation; committee representatives include a neonatologist and a pediatrician.</p> <p>The Women's Health Committee is scheduled to meet quarterly beginning in 2013. Plan has been experiencing difficulty in attracting members to attend. The March 2013 agenda was provided onsite.</p>	
The committee shall meet on a regular basis and activities		Full	The QMMC must meet at least 8 times per	



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<p>of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.</p>			<p>year, and committee minutes document nine QMMC meeting during the review period; participation and discussion are very active; the plan provides committee minutes to DMS in quarterly reports.</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 regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.</p>		<p>Full</p>	<p>Delegation oversight reports, which include quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the Delegation Oversight and QMMC committees.</p> <p>Quality and data submission information is included in the Provider Manual, and QAPI activity requirements; encounter record submissions are included in contracts and employment agreements.</p> <p>QI Work Plans and committee minutes include discussion of and provision of feedback for subcontractor QI activities; delegation oversight of subcontractor QAPI activities is included in the QI Program Evaluation.</p>	
<p>Other management activities – Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, Provider Services, etc. – shall be integrated with the QAPI program, either directly or</p>		<p>Full</p>	<p>Delegation oversight reports, which include quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the</p>	



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indirectly as part of the UM and/or QI program description or other Plan policies and procedures.			<p>Delegation Oversight and QMMC committees. Quality and data submission information is included in the Provider Manual, and QAPI activity requirements; encounter record submissions are included in contracts and employment agreements.</p> <p>QI Work Plans and committee minutes include discussion of and provision of feedback for subcontractor QI activities; delegation oversight of subcontractor QAPI activities is included in the QI Program Evaluation.</p> <p>The QI Program Description states that Quality Improvement activities are coordinated with other performance monitoring activities and management functions including, but not limited to utilization management, case and disease management, health management, risk management, patient safety, cultural and linguistic competency, credentialing, claims, member and provider services, and network development.</p>	



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The 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 care and services to all Members, including those with special health care needs, use of preventive services, 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 role shall be submitted to the Department upon request.	<p><b><u>Recommendation for PHP</u></b>            PHP should ensure careful monitoring of timeliness of review of sentinel events</p> <p><b><u>PHP Response:</u></b>            None</p> <p><b>Substantial Compliance</b></p>	Full	<p>The QI Work Plans and QI Program Evaluation provide evidence of staffing levels sufficient for comprehensive quality improvement activities.</p> <p>Departments throughout the plan participate in QI activities and collaborate across departments, including Member Services, Provider Relations and medical management.</p> <p>The Sentinel Events and Member Concerns Activity Summary document tracked sentinel events for 2012. In 2012, 146 sentinel events were referred to Quality for follow-up.</p>	
The work plan shall be submitted to the Department on a quarterly basis thirty (30) working days after the end of the quarter.		Full	<p>Work Plans were submitted on a quarterly basis within 30 working days of the end of the quarter.</p> <p>A July 30, 2012 letter to DMS was submitted onsite that documented submission of the quarterly Work Plan.</p>	
<b>Monitoring and Evaluation</b>				
(a) The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an	<p><b><u>Recommendation for PHP</u></b>            PHP should ensure adherence to the</p>	Full	The 2011 QI Program Evaluation and QI Work Plans contain evidence of ongoing monitoring	



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ongoing basis. Health care needs such as acute or chronic conditions, high volume, and high risk, special needs populations, preventive care, shall be studied and prioritized for 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>HEDIS auditor corrective action plan and ensure accuracy of medical record data collection</p> <p>PHP could consider including inpatient and ED visit data in evaluation of special needs populations, since decreasing inpatient and ED visits is identified as a means of measurement in the QI Program Evaluation for identification of need for additional programs</p> <p><b><u>PHP Response:</u></b> None</p> <p><b>Substantial Compliance</b></p>		<p>and evaluation of clinical care quality, including trending of standardized quality indicators (HEDIS measures, Healthy Kentuckian measures), special needs population case management/disease management metrics, utilization metrics and trending of sentinel events and member concerns. HEDIS measures are used to identify adherence to guidelines as well as over- and under-utilization and access.</p> <p>PHP's HEDIS auditor did not indicate any corrective action plans or note any concerns in their HEDIS Final Audit Report for 2012.</p>	
(b) Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.		Full	PHP performs ongoing monitoring of adherence to clinical practice guidelines using HEDIS measures and medical record review; the plan provided reports of audits of provider compliance with clinical practice guidelines using HEDIS measures (coronary/vascular conditions, hypertension and diabetes) as well as other medical record review (perinatal care).	
Areas identified for improvement shall be tracked and		Full	Results are tracked and trended, and reports	



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corrective actions taken as indicated.			are generated for each clinical practice guideline.  Results are reported in the 2011 QI Program Evaluation, and opportunities identified.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.		Full	Providers are re-evaluated after corrective action, and the audit schedule is documented in the QI Work Plan.	
(c) The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.		Full	Multiple departments participate in QI activities, and staff from various departments is represented on the QMMC, including the Pharmacy Director, UM, Medical Management, Clinical Programs, and Member Services; the QMMC also includes representation from a range of provider disciplines.	
(d) The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.		Full	PHP submits PIP documentation and other quality and performance improvement documentation to DMS upon request, including documentation submitted in quarterly reports and ad hoc requests for documentation are discussed during QI Work Group meetings.  PHP completed PIP reports for four projects it conducted in 2011-2012.	



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(e) The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.		Full	Clinical practice guidelines (CPG) are reviewed and approved by the Quality Medical Management Committee (QMMC) and distributed to affected plan practitioners. Once guidelines have been approved, they are reviewed and updated at a minimum of every two years or earlier based on when national standards are published and updated. Annually, Quality Improvement (QI) monitors practitioner performance against at least four clinical practice guidelines and identifies opportunities for health plan wide quality improvement activities.	
(f) The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;		Full	PHP's Clinical Practice Guidelines are systematically developed descriptive tools or nationally recognized standardized specifications for care that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.	
consider the needs of Members;		Full	Guidelines are relevant to the needs of members, and are updated and expanded as documented in the review period.	
developed or adopted in consultation with contracting health professionals, and		Full	All clinical guidelines are approved through QMMC and the Partnership Council before adoption by the plan.	



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			There is evidence of review of guidelines by providers in the plan's PCP Workgroup minutes, as well as in QMMC minutes.	
reviewed and updated periodically.		Full	All CPGs adopted by the health plan are reviewed upon receipt of new scientific evidence or national standards, or at a minimum of every two years. 1. New scientific evidence may be identified through updated National Guidelines. 2. As updated, sources utilized for CPG adoption and revisions are reviewed for changes relevant to the adopted guideline.	
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	P/P UM 35 defines the processes utilized to evaluate a proposed treatment plan, appropriate location, level of care, and duration of service as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.  The QI Program Evaluation states that PHP adopts, maintains, and implements clinical practice guidelines that support clinical management of acute and chronic conditions relevant to the Plan's membership.	



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<b>5.5 Kentucky Healthcare Outcomes Measures and Performance Measures</b>				
<p><b>Kentucky Outcomes Measures</b> The Contractor shall be required to implement steps targeted at improvement for selected measures, identified in Attachment III, 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, although the number of all performance improvement topics, QI activities, and/or initiatives shall not exceed three activities at one time. A collaborative work group comprised of DMS, PHP and EQRO staff has undertaken a comprehensive measure development task. Goals of this work group will include the development of new measures that are clinically sound, consistent with Healthy Kentuckians goals, and that will complement PHP's quality improvement goals.</p>		Full	Healthy Kentuckian measures are trended and analyzed in the QI Program Evaluation and opportunities for improvement and activities to address deficiencies are identified; activities to improve Healthy Kentuckian measures are noted in the QI Work Plans and in the plan's Performance Improvement Projects (PIPs); PHP participates in the collaborative QI Workgroup, which addresses measure development and specification revision.	
For the 2009 reporting year, the Contractor will report the measures as developed by the workgroup, and delineated in Attachment III.		Full	<p>The plan reported Healthy Kentuckian measures, including those developed by the workgroup for the 2009 and 2010 reporting years.</p> <p>These measures included measures that address Normal Body Weight for Height for Adults and Children; Reduced Morbidity from</p>	



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			Hypertension; Reduced Incidence of Dental Caries in Children; the Kentucky Cabinet for Health and Family Services Childhood Lead Poisoning Prevention Program; Reducing Infant Mortality, Incidence of LBW/VLBW, and Incidence of Birth Defects; Increasing the Proportion of Adults with Cholesterol Screening; Increasing Screening and Counseling for Adolescent Risk Behaviors; Early and Periodic Screening, Diagnostic and Treatment Services; and Access to Care and Preventive Care for Individuals with Special Health Care Needs- Children and Adolescents.	
In the event that either federal or state priorities change; findings and/or recommendations from EQR; 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 Attachment III. Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.		Full	Amendments to specifications based on performance measure validation findings were discussed in the QI workgroup and specifications updated; specifications are also updated to be consistent with changes to HEDIS measures.	
The Contractor in collaboration with the Department and		Full	A performance measure specific to individuals	



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the EQRO shall develop and initiate a performance measure specific to ISHCN.			with special health care needs (Children and Adolescents) was developed and initiated during the review period in collaboration with DMS and the EQRO.	
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.	<p><b><u>Recommendation for PHP</u></b>            The plan should identify issues related to reporting of BMI percentile for reporting year 2010</p> <p>The plan should monitor and ensure continued improvement for BMI percentile documentation and perinatal screening</p> <p><b><u>PHP Response:</u></b>            This issue is currently being discussed in the monthly QI work group calls with DMS and IPRO.</p> <p><b><u>IPRO Comments:</u></b>            No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>For reporting year 2010, the plan demonstrated improvement for most Healthy Kentuckian measures.</p> <p>For reporting year 2012, PHP was above the national Medicaid mean for the Adult BMI measure as well as for the Timeliness of Prenatal Care and Postpartum Care measures.</p>	
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		Substantial	Performance measure rates, trending and identified barriers are documented in the 2011 QI Program Evaluation, and activities relevant	<b>MCO Response:</b> Passport Health Plan accepts the recommendation and updated the 2013 QI Work plan to



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plan quarterly and shall submit an annual report after collection of performance data.			to the measures are evident in the QI Work Plan, which is updated quarterly and submitted in quarterly reports. Performance measures were submitted in an annual report for 2010 and 2011.  <b>Recommendation for PHP</b> PHP should consider including quantifiable goals more consistently in the QI Work Plan, e.g., a goal for "Decreasing Preterm Deliveries".	include quantifiable goals. While Passport continues to assess its results against the Quality Compass® Mean, the Quality Compass® 90th Percentile benchmark is used as the ultimate goal for HEDIS® performance measures.  <b>IPRO Comments:</b> No change in review determination.
<b>HEDIS Performance Measures</b> The Contractor shall be required to collect and report HEDIS data annually .After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31 <sup>st</sup> .		Full	PHP provided the HEDIS Final Audit Report and Supplemental Audit Report dated July 2012 for review. The Final Audit Report and Review Table demonstrated that all measures within PHP's audit scope were reportable.  DMS received submission of the Final Auditor's Report and DSS by August 31.	
<b>5.6 Performance Improvement Projects (PIPs)</b>				
The Contractor is expected to continuously monitor its own performance on a variety of dimensions of care and services for enrollees, identify areas for potential improvement, carry out individual Performance Improvement Projects (PIPs), undertake system interventions to improve care and		Full	During the review period, PHP was engaged in the conduct of PIPs addressing Emergency Room Utilization, Reduction of inappropriately Used Antibiotics, Dental Care for Children with Special Health Care Needs, Smoking Cessation	



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<p>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 that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Clinical PIPs should address preventive and chronic healthcare needs of the member's populations and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. Program initiatives 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 its members and providers, such as aspects of service including, but not limited to availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.</p>			<p>and Childhood Obesity.</p> <p>The chosen PIP topics address clinical areas relevant to the plan population, including the prevention of chronic conditions; the PIPs address access as well as clinical care, and in the Dental Care PIP the needs of a subpopulation based on eligibility category; culturally competent services are addressed in some of the PIP interventions, as are non-clinical aspects of care such as access.</p> <p>PHP reports HEDIS annually and evaluates rates in the QI Work Plan.</p>	
<p>The Department strongly encourages the development of collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.</p>		Full	<p>PHP evidenced collaboration with local entities in its PIP on improving Dental Care Access where it participated in five community events. For its PIP on Reducing Emergency Department utilization, PHP collaborated with two hospitals.</p> <p>The Work Plan notes participation in community events.</p>	



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			PHP includes a Health Department representative on the QMMC.	
The Department and the Contractor shall be jointly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of best practices and use of encounter data-driven performance measures.		Full	PHP participates with DMS and the EQRO in monthly QI workgroup meetings, during which quality activities and development and revision of performance measures are discussed; progress on PHP's PIPs is an agenda item for each discussion.	
The Contractor shall annually monitor and evaluate the quality of care and services through the initiation of one (1) new performance improvement project each contract year from the areas listed below; or the Contractor may propose alternative performance improvement topics to be addressed by submitting a written request via a proposal to the Department. In addition to the performance improvement projects referenced immediately above, the Department may require Contractor to implement not more than one additional performance improvement projects specific to the Contractor based on findings from EQRO and/or audit as directed by CMS and submit reports as required. In addition, the Contractor may be required to assist the Department with one (1) annual statewide project. The total number of performance improvement activities, including new and recurring PIPs, QI activities shall not exceed three at any one time, with the exception of participation in one statewide project at a time. The	<p><b><u>Recommendation for PHP</u></b> PHP should ensure timely submission for all PIP reports</p> <p><b><u>PHP Response:</u></b> Passport Health Plan will ensure the timely submission of all required reports and documentation.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	PHP is currently conducting four PIPs. Reports for each of the four PIPs were completed and submitted on 8/31/12.	



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Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit periodic reports utilizing the PIP proposal and reporting template provided by the Department. The timeframes for reporting: (as delineated in contract, annually, September 1 for Project proposal, baseline measurement, 1 <sup>st</sup> re-measurement, 2 <sup>nd</sup> re-measurement)				
(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	PHP initiates a new performance improvement project each year. Proposals were submitted on September 1 <sup>st</sup> .	
(b) Baseline Measurement – due at a maximum, one (1) calendar year after the project proposal and no later than September 1 of the contract year and may be given at the time of project proposal, if available.		Full	The four PIPs have established Baselines that were within the timeframes required.	
(c) 1 <sup>st</sup> Remeasurement no more than two (2) calendar years after baseline measurement and no later than September 1 of the contract year		Full	The PIPs have remeasurement periods one year after baseline was established.	
(d) 2 <sup>nd</sup> Remeasurement no more than one (1) calendar year after the first remeasurement and no later than September 1 of the contract year (NOTE-see chart page 47 of contract for illustration purposes)	<b>Recommendation for PHP</b> PHP should ensure timely submission for all PIP reports  <b>PHP Response:</b>	Full	The PIPs have 2 <sup>nd</sup> remeasurement periods that occurred or are planned for, that are one year after the first remeasurement period.	



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	None  <b>Substantial Compliance</b>			
As indicated above, the Contractor shall implement PIPs in any clinical or non-clinical focus area set forth below, or in another Contractor-proposed focus area if a quality improvement opportunity is identified. QI projects must address varied focus areas over time, measure diverse aspects of care, and care provided to diverse member populations. While PIPs should address and improve the quality of care and service provided to the majority of members, the Contractor must also ensure that PIPs are not limited to only recurring, easily measured topics but also address vulnerable subpopulations who may not be great in number, are those at high risk or in greatest need, as agreed upon by the workgroup (EQRO, DMS and the Contractor).		Full	The topic areas are varied and address diverse populations, including children and adults, and also children with special health care needs.  The topics represent areas of special concern for the plan due to prevalence and significant impact on health (smoking, appropriate antibiotic usage), dental care and oral health and improving appropriate access of care (reduction of ER usage).	
Clinical: Focus Areas - Primary, secondary, and/or tertiary prevention of acute and chronic conditions; care of acute and chronic conditions; high-volume services; high-risk services; continuity and coordination of care.		Full	PIP topics address clinical focus areas, including prevention and treatment (smoking, dental care, and antibiotic usage) and access (ER usage).	
Non-Clinical: Focus areas - Availability, accessibility, and cultural competency of services; appeals, grievances/ complaints.		Full	The PIP on reducing ER usage directly targeted improving access to appropriate care. The other PIPs, though clinical in focus, addressed member services.	
Performance Improvement Projects (PIPs) are required to		Substantial	The PIP topics were chosen based on analysis	<b>MCO Response:</b> Passport Health Plan



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address and achieve significant (demonstrable) and sustained improvement in focus areas for three (3) years or for the duration of the PIP. Selection of PIP topics should encompass: continuous data collection and analysis of comprehensive aspects of patient care and member services; continuous monitoring of population needs and preferences and organizational performance; identification of areas of opportunities for improvement; and systematic prioritization based on clear criteria. Because the achievement of significant and sustained improvement is a central criterion for evaluation, PIPs must necessarily focus on areas where significant improvement can be effected through system interventions. The Contractor should give priority to areas in which there is significant variation in practice; poor resulting outcomes; or for which performance as a whole falls below acceptable benchmarks or norms.			<p>of plan data and identification of population need (Dental Care), identification of opportunity for improvement (ER usage) as well as conditions that are relevant to and prevalent in the population that can be impacted by the plan (smoking). The plan developed interventions likely to impact these focus areas.</p> <p><b><u>Recommendation for PHP</u></b> PHP should explicitly state in its PIP reports interventions that will continue beyond the life of the PIP if systematic improvement in care delivery was evidenced. Mechanisms for ensuring sustainability of success should be discussed in the reports as well.</p>	<p>accepts the recommendation and will update the 2013 PIP reports to reflect that interventions continue beyond the life of the PIP and note identified evidence of systematic improvement in care delivery. The 2013 PIP report updates will also denote mechanisms that ensure sustainability of success.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>
The Contractor's affiliated providers and members must have opportunities to participate in the selection PIP topics via the Partnership Council.		Full	Providers and members and member advocates are represented on the Partnership Council; PIPs are also discussed in provider and member committees.	
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 appropriateness and relevance of the PIP, the reliability and validity of the data collected, results and the conclusions		Full	Using the DMS provided PIP template, PHP reported each of the four PIPs and addressed data collection methodology, barriers and interventions that address the barriers, progress of interventions and effectiveness,	



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drawn, the effectiveness of the interventions, and the achievement of improvement:			results, analysis and interpretation of results, limitations, improvement achieved, lessons learned and next steps.	
<b>5.7 Quality and Member Access Advisory Committee</b>				
The Contractor shall establish and maintain an ongoing Quality and Member Access Advisory Committee composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population and public health representatives.		Full	<p>The Plan's Quality and Member Access Advisory Committee (QMAC) meets at least four times a year and is comprised of member representatives.</p> <p>The QMAC includes representatives of children with special needs/foster care , aged populations, children and families, disabled/blind populations, public health representatives, the Commission for Children, homeless advocates and an education advocate.</p>	
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	<p>Membership is comprised of members, consumer advocates, educators, and public health officials who represent the public health interest and diversity of the membership, as appointed by Partnership Council.</p> <p>Appointments are made with consideration to geographic, age, gender, and aid category, as well as racial and ethnic diversity.</p>	



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(a) Providing review and comment on quality and access standards;		Full	The QMAC reviewed and approved network development and practitioner access and availability reports as well as access goals as noted in committee minutes. The committee minutes also reflect review of HEDIS results, member satisfaction results and case management performance results, as well as Member Services metrics.	
(b) Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;		Full	Review of Member Services performance reports as well as grievance and appeals trends are documented in QMAC committee minutes.	
(c) Review and provide comment on Member Handbooks;	<p><b><u>Recommendation for PHP</u></b> The QMAC should be involved in review of changes to the Member Handbook in order to incorporate QMAC input</p> <p><b><u>PHP Response:</u></b> The Plan will present future Member Handbook update's to QMAC to ensure member involvement and input.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Non-Compliance</b></p>	Full	<p>There was no reference to discussion about the Member Handbook in the minutes for the five QMAC meetings held in 2012.</p> <p><b><u>Corrective Action Plan</u></b> In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), 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><b>MCO Response:</b> Passport Health Plan disagrees with the scoring of this element for the following reason:</p> <p>The Member Handbook was presented to QMAC on December 12, 2012 for review, discussion, and approval under New Business of the QMAC meeting minutes on page four. Documentation states:</p> <p><b>Topic:</b> Member Handbook. <b>Discussion:</b> Ms. Roland presented the 2013 Member Handbook and inserts. In response to questions, Ms. Roland</p>



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				<p>reported that all PHP members will be mailed a confirmation letter, a new handbook, and an identification card on 12/27/12.</p> <p><b>Action:</b> On a motion by the members present, the Quality Member Access Committee unanimously approved the PHP Member Handbook for 2013.</p> <p>In addition, Passport's Quality Department monitored this process to ensure that Member Handbook updates were presented to QMAC to ensure member involvement and input. Documentation in the QI Work plan, 4<sup>th</sup> quarter 2012, page 59 states:</p> <p>4<sup>th</sup> Quarter  The following were presented to QMAC for review, input, and approval:</p> <ul style="list-style-type: none"> <li>• Member Handbook Review <ul style="list-style-type: none"> <li>○ Handbook</li> <li>○ Inserts</li> </ul> </li> </ul> <p>The December 12, 2012 QMAC meeting minutes and the 2012 QI</p>



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				Work plan will be resubmitted to the EQRO (See attached).  <b>IPRO Comments:</b> Review determination changed to Full. Minutes for 12/10/12 QMAC meeting demonstrate review of Member Handbook.
(d) Reviewing Member education materials prepared by the Contractor;		Full	The 8/8/12 minutes of the QMAC meeting indicated that an evaluation was undertaken regarding the readability of the online provider and pharmacy directories.	
(e) Recommending community outreach activities; and		Full	The 9/19/12 minutes of the QMAC meeting reported on a special event at the Louisville Zoo and a Health Hoops program for members with asthma.	
(f) Providing reviews of and comments on Contractor and Department policies that affect Members.		Full	The QMAC minutes include a review of clinical practice guidelines, the QI Program Description and Evaluation, QI Work Plans, Member Services performance reports, member grievance and appeals trend reports, member satisfaction, and HEDIS and CAHPS reports, as well as PIPs.	
The Contractor shall pay reasonable costs of expenses for members to participate in Quality and Member Access	<b>Recommendation for PHP</b> PHP should ensure that members are	Full	PHP updated its QMAC policy to include reimbursement for transportation and child	



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State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Advisory Committee activities.	<p>aware of coverage of expenses for participation in the QMAC and include this information in plan documents</p> <p><b>PHP Response:</b> PHP will update the policy with information regarding covered expenses for participation in QMAC and in Plan documents. The updated policy will be presented to QMAC in 2012 to ensure member awareness.</p> <p><b>IPRO Comments:</b> No change in review determination.</p> <p><b>Non-Compliance</b></p>		care expenses to attend the meetings.	
The list of the Members participating with the Quality Member Access Advisory Committee shall be submitted to the Department annually.		Full	The QMAC minutes include members that attended and members who were absent from the meeting.	
<b>5.10 Assessment of Member and Provider Satisfaction and Access</b>				
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		Full	The plan conducted an annual member CAHPS survey and provider satisfaction survey during the review period and reports were provided; results were presented to the QMMC.	



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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.				
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.		Full	The CAHPS survey tool was provided to DMS.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	<p><b><u>Recommendation for PHP</u></b> PHP could consider additional surveys based on QAPI observations, such as high rates of postpartum readmissions</p> <p><b><u>Recommendation for DMS</u></b> DMS should consider collaborating with PHP to identify subpopulations for special surveys in the QI Work Group</p> <p><b><u>DMS Response:</u></b> DMS will work with PHP in identifying subpopulations for special surveys; these issues may be identified based on results of HEDIS and performance measures, focus studies, utilization reports, discussions in the QI workgroup and feedback from other sources</p>	Full	<p>PHP developed a survey that is in progress to assess the satisfaction of their DCBS population.</p> <p><b><u>Recommendation for PHP</u></b> PHP should consider adding supplemental questions to the annual CAHPS survey that assess satisfaction/access to services targeted to subpopulations of their membership.</p>	<b>MCO Response:</b> None



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	<p><b><u>PHP Response:</u></b> PHP appreciates the opportunity to work with DMS regarding subpopulations for special surveys.</p> <p><b><u>I PRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approve the Contractor's current provider satisfaction survey tool as approved by the Partnership Council.		Full	<p>The 2011 Practitioner Satisfaction Survey Tool was presented to the Partnership Council on 9/20/11.</p> <p>The plan submitted the provider satisfaction survey tool to DMS.</p>	
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.		NA	DMS responsibility.	
The Contractor shall provide the Department a copy of the survey results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument as		Full	<p>The 2012 Adult and Child CAHPs survey reports were provided to DMS on 7/30/12.</p> <p>The Partnership Council approved the provider survey on 9/20/11.</p>	



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approved by the Partnership Council, shall be submitted to the Department along with the findings and interventions conducted or planned.				
All survey results must be reported to the Department, and upon request, disclosed to Members.	<p><b><u>Recommendation for PHP</u></b> The plan should ensure that the current QI Program Evaluation is available to members on request, and update the website-posted QI Program Evaluation</p> <p><b><u>PHP Response:</u></b> None</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	PHP provided screenshots of the website that reference member surveys.	
<p><b>5.11 QAPI Reporting Requirements</b> 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 or paper format.</p>		Full	The plan provides quarterly reports that include the QAPI Work Plan and other required quality activity reports. An email sent to DMS on 1/30/12 was presented as an example.	
<b>Reference the following documents for further information:</b>				



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<b>1. Attachment III Health Outcomes, Indicators, and Goals</b> <b>2. Attachment XI Reporting Requirements</b>				



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**Scoring Grid:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	82	4	0	0
Total Points	246	8	0	0

**Overall Compliance Determination:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Range	<b>3.0</b>	<b>2.0 – 2.99</b>	<b>1.0 – 1.99</b>	<b>0 – 0.99</b>
Points Average		<b>254/86=2.95</b>		

**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



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**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 and minutes  
Committee description and minutes for Partnership Council, QMMC, QMAC, PCP Workgroup  
Clinical Practice Guidelines  
Provider Manual  
Provider Newsletters  
Provider Committee minutes

**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  
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



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■ = Not Subject to Review

<b>Grievance System</b> <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
<b>7.2 Grievance System</b>				
The Contractor shall have an organized Grievance system that shall include a Grievance process, an Appeal process, and access for Members to the State's hearing system. Any Member has a right to file a Grievance with the Contractor or the Department if they are dissatisfied with anything related to the Partnership Program. Any Member may file an Appeal related to Actions, or a decision by the Contractor related to Covered Services or services provided.		Full	<p>PHP has a comprehensive grievance process that is outlined in P/Ps CP5.11, CP5.12, CP5.13, and CP5.14 and also in P/Ps MS16.0 and MS24.0.</p> <p>Grievances and appeals are also referenced in the Member Handbook. The right of members to file grievances and appeals with the plan or Department is described in policy and the Member Handbook, including the right to appeal any action by the plan, request a State hearing or contact the Medicaid Ombudsman at any time; the Member Handbook includes information on how to file a grievance or appeal for a decision made by the plan, and how to access the State's hearing system.</p>	
The Contractor shall acknowledge receipt of each Grievance and Appeal. The Contractor shall provide notice to the Member and must ensure that decision-makers on Grievances and Appeals were not involved in previous levels of review or decision making and are health care professionals with clinical expertise in treating the Member's condition if: (a) A Denial based on lack of Medical Necessity;	<b>Recommendation for PHP</b> PHP should clarify in policy that any quality of care concern is referred to the Quality Department, including PCP change requests that are based on care concerns; including explicit examples of key quotes and categories that should be referred to the Quality Management Department, such as	Minimal	<p>MS16.0 has yet to be updated. The last update was 7/31/12 and was approved without change.</p> <p><b>Corrective Action Plan</b> In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), the MCO is required to submit</p>	<p><b>MCO Response:</b> MS 16.0 has been updated to reflect that even if a PCP is changed due to a dissatisfaction and the below Quality triggers are met the grievance is to be routed to Quality Management for review.</p> <p>Per Policy MS 16.0:</p>



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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>(b) A Grievance regarding denial of expedited resolutions of an appeal; and (c) Any Grievance or Appeal involving clinical issues.</p>	<p>those in the Quality of Care Review document, should be incorporated into policy for clarity; a request for change of PCP should be viewed as a possible indicator of care concerns</p> <p><b><u>Recommendation for DMS</u></b> DMS should continue to work with PHP on updating policies relevant to quality of care concerns</p> <p><b><u>DMS Response:</u></b> DMS will continue to participate and work collaboratively on the QI calls with PHP and EQRO on a monthly basis; DMS will continue to monitor PHP's quarterly reports; PHP should update policies to reflect appropriate review of QOC concerns.</p> <p><b><u>PHP Response:</u></b> The two Policies (MS 16.0 and MS 24.0) are two different policies and the time frames are different.</p> <p>MS16 is Member Services' Grievance Process which does state we will contact the member within 24 hours of receiving</p>		<p>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>	<ul style="list-style-type: none"> <li>• All grievances related to the following are routed to Quality of Care via EXP for a nurse review: (See Policy QM1.01)</li> <li>• Diagnosis and Treatment Concerns – all concerns/grievances in regards to symptoms, diagnosis, diagnostic procedures, and medical condition.</li> <li>• Environmental Concerns – condition of office, office equipment, office parking lot, office odors, uncomfortable temperature in waiting area or patient exam rooms, and equipment malfunction.</li> <li>• Safety Concerns – medication errors, any accident or injury while at the provider's office, improper disposal of biohazard materials, and poor or no infection control practices.</li> <li>• HIPPA Privacy Concerns – other patient medical records in view, any loud conversations overheard about other patients.</li> </ul> <p><b>IPRO Comments:</b> No change in review determination.</p>



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	<p>their written grievance.</p> <p>MS24.0 is a Member Appeal policy and states that PHP will contact a member within 3 business days. This policy's wording was taken from CP5.11 which is Pre Service Appeals and is a Medical Management Policy.</p> <p>Policy MS. 16.0 is being updated to reflect allowable PCP changes as well as adding the document entitled "Quality Improvement-Quality of Care Review for Member Concerns/Complaints" as a part of the policy. If a PCP change request is made by a member due to a quality of care concern the grievance will be forwarded to Quality for review.</p> <p>The Special Support Technicians are non-clinical associates. In analyzing the grievances that were not forwarded correctly related to one technician, which was a misunderstanding and training issue. A new process has been established for all Technicians which include a peer review where each of the Technicians will review each other's documentation to ensure that</p>			



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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>all policies are followed to result in a complete resolution. Trainer/Auditor will continue monthly audit reviews.</p> <p>MS 16.0 member grievance policy number 1 – G will be updated to reflect:</p> <ul style="list-style-type: none"> <li>• Diagnosis and Treatment Concerns – all concerns/Complaints in regards to symptoms, diagnosis, diagnosis procedures, and medical condition.</li> <li>• Environmental Concerns- Condition of office, office equipment, office parking lot, office odors, uncomfortable temperature in waiting area or patient examination rooms and equipment malfunction.</li> <li>• Safety Concerns-medication errors, any accident or injury while at the provider's office, improper disposal of biohazard materials, and poor or no infection control practices.</li> <li>• HIPPA Privacy Concerns- other patient medical records in view, any loud conversations overheard about other patients.</li> </ul> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p>			



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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>Minimal Compliance</b>			
<b>7.2.1 Grievances</b>				
Any Member shall have the right to file a Grievance with the Contractor if they are dissatisfied with a matter regarding the management of their care. Any dissatisfaction concerning an eligibility matter shall be filed with the Department for Community Based Services.		Full	The right of any member to file a grievance is noted in the Member Handbook and PHP policies and procedures; the Member Handbook refers the member to DCBS for eligibility questions and states the ability to contact the Kentucky Ombudsman for complaints about DCBS.  <u>Grievance File Review</u> 35 of 35 grievance files reviewed were addressed within the 90 day timeliness standard from receipt of request.	
<b>7.2.1.1 Contractor Grievance Process</b>				
The Contractor shall have a timely and organized system with written policies and procedures for resolving Grievances filed by Members. This process shall conform to 42 CFR 438 subpart F and other applicable CMS and DMS requirements. The Contractor shall have a process that consists of methods to address Member's oral and written Grievances.	<b>Recommendation for PHP</b> The plan should ensure documentation of resolution date for cases that are referred to other departments for investigation  <b>PHP Response:</b> Documentation does reflect Resolution dates within these cases.	Full	P/P CP5.13 states that an extension of 14 days can be granted at the member's request, or if the appeals research specialist determines that there is need for additional information and that a delay is in the member's interest, the plan may extend the timeframe by up to 14-calendar days and a written notice of the extension is sent to the member.	



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	<p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>		<p>The date that the case is closed is included in PHP's member grievance form.</p>	
<p>The Contractor shall have an adequately staffed Member Services function that can receive telephone calls and meet with members face-to-face to answer questions and attempt to resolve Grievances.</p>		Full	<p>P/P MS 16.0 refers to Special Support Technicians who are responsible for handling grievances.</p> <p><b><u>Grievance File Review</u></b> In the review of the files, all cases were addressed in a timely manner, many within the same day.</p>	
<p>Every Grievance received shall be documented in the Contractor's Management Information System. The documentation process must be approved by DMS and shall contain the following information:</p>	<p><b><u>Recommendation for PHP</u></b> PHP policy regarding QOC concerns is being drafted by PHP and reviewed by EQRO and DMS as part of the QI call</p> <p><b><u>PHP Response:</u></b> Although we have multiple systems within other departments for their reporting needs, all Member grievances are forward to Member Services via EXP for investigation and resolution.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p>	Substantial	<p>P/P MS 16.0 notes that all member grievances are documented in the EXP system, which is an electronic tracking system that can be used for real-time communication across departments; the plan records, tracks and reports on all member and provider inquiries in the EXP system. Reports of grievances received were provided onsite.</p> <p><b><u>Recommendation for PHP</u></b> A QOC concern policy is being drafted for release in 2013.</p>	<p><b>MCO Response:</b> Passport Health Plan accepts the recommendation and has updated the Policy QM 15.00, Quality Member Concerns, as well as Policy MS 16.0, Grievance Intake Process. The updated policies are attached for your review.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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	<b>Substantial Compliance</b>			
(a) Member Name and Identification Number;		Substantial	<p>Of the 35 grievances reviewed, one was missing member name and was referred to as "unknown" member.</p> <p><b>Recommendation for PHP</b> The MCO should ensure that grievance files include member identification.</p>	<p><b>MCO Response:</b> The one referenced "unknown" member was PHP staff error. Staff has been educated to follow MS 16.0 Policy as listed below for all grievances. All grievances will be documented in the EXP system and include:</p> <ul style="list-style-type: none"> <li>•Information to identify the grievances.</li> <li>•Member's ID number.</li> <li>•Member's Name – ADDED TO POLICY</li> <li>•Individual and group Provider ID number.</li> <li>•The caller's name, relationship to the member, and phone number.</li> <li>•Member's current PCP ID number and name.</li> <li>•Member's county of residence.</li> <li>•Date received.</li> <li>•The type of grievance being filed.</li> <li>•Nature of the grievance.</li> <li>•Notice to member of receipt.</li> <li>•All correspondence between Passport and the member.</li> <li>•Resolution Date.</li> <li>•Decision.</li> <li>•Notice of final decision to member.</li> </ul>



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				<b>IPRO Comments:</b> No change in review determination.
(b) Member's telephone number, when available;		Full	The member's telephone number was documented in all 35 cases reviewed, including the "unknown member".	
(c) Nature of Grievance;		Full	The nature of the grievance was documented in all 35 cases reviewed.	
(d) Date of Grievance;		Full	The date of the grievance was documented in all 35 cases reviewed.	
(e) Member's PCP;		Full	The member's PCP was documented in all 35 cases reviewed.	
(f) Member's County of Residence;	<p><b><u>Recommendation for PHP</u></b> 44/45 member grievances included the member's county of residence; only one case was missing this information</p> <p><b><u>PHP Response:</u></b> This was an oversight by one Technician as stated within the Quality issues. Training was provided.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p>	Full	The member's county of residence was documented in all 35 cases reviewed.	



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	<b>Substantial Compliance</b>			
(g) Resolution;		Substantial	<p>The resolution was documented in all 35 cases reviewed although the appropriateness of the resolution was questionable in a few cases, as noted below.</p> <p><b><u>Recommendation for PHP</u></b> PHP should ensure that appropriate follow-up is undertaken even when the immediate issue has been addressed. For example, in one case a member complained that her son was not getting braces. PHP intervened to ensure that the child received the braces. However, PHP should have counseled the member about proper use of the braces since the patient was continually damaging them, which is why the dentist was reluctant to continually refit the child with new braces.</p>	<p><b>MCO Response:</b> PHP accepts recommendation. The Special Support Technician followed policy, however, failed to provide proper documentation showing the member was educated on proper treatment for braces. Additional training has been provided to the Special Support Technicians.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>
(h) Date of Resolution;	<p><b><u>Recommendation for PHP</u></b> The plan should ensure that resolution date is tracked for those cases referred to other departments</p> <p><b><u>PHP Response:</u></b> Documentation does reflect resolution dates within these cases.</p>	Full	<p>The resolution date was documented in all 35 cases reviewed.</p>	



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	<p><b><u>IPRO Comments:</u></b> Documentation in file did not include date of resolution by Provider Relations. No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
(i) Corrective action taken or required; and	<p><b><u>Recommendation for PHP</u></b> The plan should clarify in policy whether complaints regarding unprofessional behavior are referred to Provider Relations, and whether these complaints are included in PCP complaint data that is compiled as described in PR 20.00</p> <p>PHP should clarify in policy that any quality of care concern is referred to the Quality Department, including PCP change requests that are based on care concerns; including explicit examples of key quotes and categories that should be referred to the Quality Management Department, such as those in the Quality of Care Review document</p> <p>The plan should clarify in policy how it will be determined that quality of care concerns warrant further investigation and what the</p>	Minimal	<p>All 35 cases, as indicated, had documentation of corrective action that was taken but for several cases, it was not clear that the resolution was appropriate or that appropriate follow-up was undertaken:</p> <ol style="list-style-type: none"> <li>1. One member complained that she was not able to get the medication she needed. PHP intervened to make sure she received her medication but there was no documentation that the provider was contacted to ensure that this oversight did not reoccur, other than PHP noting that it would "monitor the provider"</li> <li>2. One member was not identified ("unknown member".) This member was dissatisfied with the auto-assigned provider. The resolution stated that the member's address was updated and verified but from the documentation it was not apparent that the PCP was changed.</li> </ol>	<p><b>MCO Response:</b> Passport Health Plan accepts the recommendations and has updated policies MS 16.0 and QM 15.00 to address the identified issues. The updated policies are attached for your review.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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	<p>procedure will be for such investigation; for example, the plan could consider concerns associated with deterioration of condition, unanticipated inpatient stay or ED visit that could trigger further investigation</p> <p>PHP is currently working on a review of grievance policies</p> <p>15 of 15 provider grievances were resolved; reprocessed or resubmitted on the same day; in 2 of 15 cases, a claim had been denied due to a lack of referral, although no referral is required for claims with ICD-9 codes for End Stage Renal Disease (ESRD), HIV or neoplasm; these denials were overridden; however, the plan should investigate system changes to avoid erroneous denials for these diagnoses in the future</p> <p><b>PHP Response:</b> Policy MS. 16.0 is being updated to reflect allowable PCP changes as well as adding the document entitled "Quality Improvement-Quality of Care Review for Member Concerns/Complaints" as a part of the policy.</p>		<p>3. For one member, there was no indication that feedback was provided to either the member or provider.</p> <p>4. For one member, there were no quality of care concerns noted but the follow-up process was not documented nor was there any documentation to indicate that the member was contacted to inform her of what action the PCP took to resolve the issue.</p> <p>PHP indicated that P/P MS 16.0 will be updated July 2013 to reflect allowable PCP changes and by adding the QI-QOC Review document as a cross reference to the policy.</p> <p><b>Corrective Action Plan</b> In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), 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>	



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	<p>If a PCP change request is made by a member due to a quality of care concern the grievance will be forwarded to Quality for review.</p> <p>The Special Support Technicians are non-clinical associates. In analyzing the grievances that were not forwarded correctly related to one technician, which was a misunderstanding and training issue. A new process has been established for all Technicians which include a peer review in which each of the Technicians will review each other's documentation to ensure that all policies are followed to result in a complete resolution. Trainer/Auditor will continue monthly audit reviews.</p> <p>Passport Health Plan will review the related policies and make changes as needed.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Minimal Compliance</b></p>			
(j) Person Recording Grievance.		Full	All 35 cases reviewed had documentation of	



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			the person recording the grievance.	
Supervisory oversight of Member Service representatives shall be conducted on a scheduled and as needed basis to ensure that procedures for receiving, recording, investigating and resolving member grievances meet all standards.	<p><b><u>Recommendation for PHP</u></b> PHP should establish a mechanism for Quality oversight to ensure that clinical concerns are appropriately forwarded to Quality Management or other relevant department</p> <p><b><u>PHP Response:</u></b> We have set up new processes where all technicians will review each others' grievance documentation to ensure that all policies are followed to result in a complete resolution. Trainer/Auditor will continue monthly audit checks.</p> <p><b><u>I PRO Comments:</u></b> No change in review determination.</p> <p><b>Minimal Compliance</b></p>	Substantial	<p>P/P MS 16.0 states that grievances are reported both monthly and quarterly through various reports and committees. Monthly reports are created and used to develop quarterly reports which are reported via QMAC, QMMC, and Quality of Service committee (QSC) meetings.</p> <p><b><u>Recommendation for PHP</u></b> PHP should update MS 16.0 to clearly describe a mechanism for oversight and audit by quality management staff.</p>	<p><b>MCO Response:</b> Per MS 16.0 any quality triggers are referred to the quality department for handling and advising an outcome to the quality care grievances.</p> <p>Member Services staff routinely reviews grievances to identify any trends and areas for improvement.</p> <p><b>I PRO Comments:</b> No change in review determination.</p>
<b>7.2.1.2 Grievance Policies and Procedures</b>				
The Contractor shall establish written policies and procedures for the receipt, handling and disposition of Grievances that shall comply with 42 CFR 438 Subpart F and 42 CFR 431. These policies and procedures shall:	<p><b><u>Recommendation for PHP</u></b> The plan is currently reviewing grievance policies and working with DMS and the EQRO on grievance processes</p>	Full	P/P MS 16.0 describes the grievance process and is updated annually.	



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	<p><u>PHP Response:</u> None</p> <p><b>Minimal Compliance</b></p>			
(a) Be approved by the Contractor's governing bodies or board of directors;		Full	The provision of direction and oversight of clinical care and services is delegated to the Quality Medical Management Committee (QMMC), which approves the annual QI and UM Program Descriptions and Evaluations, clinical guidelines and UM criteria, as well as administrative policies and procedures that impact members' health care.	
(b) Be approved in writing by DMS prior to implementation and shall be conducted in accordance with all applicable federal and state laws;		Full	DMS approved the grievance policies and procedures that were in place during the review period.	
(c) Include a process for evaluating patterns of Grievances for impact on formulation of policy and procedures, access and utilization;	<p><u>Recommendation for PHP</u> File review revealed that member quality of care concerns are not always forwarded from Member Services to Quality for review; this is a critical problem that prevents an accurate tracking of quality of care concerns, and consequently prevents a comprehensive evaluation and analysis of trends</p> <p>The plan should ensure that all member</p>	Minimal	<p>File review indicated that there are still instances where quality of care concerns are addressed at the member level but not followed up by the quality department to ensure that any needed system changes are made.</p> <p><u>Corrective Action Plan</u> In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), the MCO is required to submit</p>	<p><b>MCO Response:</b> PHP has updated policies MS 16.0 and QM 15.00 regarding quality of care complaints and concerns. The updated policies are attached for your review.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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	<p>quality of care concerns are tracked and trended by Quality; P/P MS 16.0, which indicates that Member Services should handle requests for PCP change, may be confusing, since a request for PCP change can be an indicator of quality of care concerns; the policy should be updated to ensure that it is clear that Member Services should forward any quality of care concern, including those that involve a request for change of PCP, to Quality for review</p> <p><b>PHP Response:</b> The Special Support Technicians are non-clinical associates. In analyzing the Grievances, for one technician, that were not forwarded correctly it was a misunderstanding and training issue.</p> <p>A new process has been established for all technicians which includes a peer review where each of the technicians will review each other's documentation to ensure that all policies are followed to ensure complete resolution. The Trainer/ Auditor will continue monthly audit reviews.</p> <p><b>IPRO Comments:</b></p>		<p>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>	



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	No change in review determination.  <b>Minimal Compliance</b>			
(d) Establish procedures for maintenance of records of Grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a Grievance or Appeal;		Full	P/P MS 16.0 notes that all grievances are documented in the plan's internal EXP system and includes all aspects of the issue, investigation, any referral to other departments, resolution and date, and communication back to member.	
(e) Inform Members, orally and/or in writing, about the Contractor's and State's Grievance and Appeal process, and by making information readily available at the Contractor's offices including service locations; and by distribution to all members upon Enrollment; to all subcontractors at time of contract;		Full	P/P MS 16.0 notes that all grievances are documented in the plan's internal EXP system and includes all aspects of the issue, investigation, any referral to other departments, resolution and date, and communication back to member.	
(f) Provide assistance to Member in filing Grievances or Appeals if requested or needed;		Full	The Member Handbook includes information on how to obtain assistance from the plan in filing grievances or appeals.	
(g) Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a Grievance or Appeal; and		Full	The Member Handbook and policies include language indicating that filing grievances or appeals will not result in discrimination and poses no threat to membership or member benefits.	
(h) Include notification to Members regarding how to access the Cabinet's ombudsmen's office regarding		Full	The Member Handbook includes information regarding how to access the Kentucky	



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Grievances, Appeals and state hearings.			Ombudsman regarding grievances, appeals and State hearings; this information is also included in acknowledgement letters for appeals.	
<b>7.2.1.3 Grievance Resolution Notices</b>				
The Contractor shall provide oral or written notice of the Grievance resolution in a manner to ensure ease of understanding and shall include the results of the resolution process and the date it was completed.	<p><b>Recommendation for PHP</b> It was not clear from documentation for 4/20 targeted grievance cases that the member was notified of the resolution; two of these cases had been referred to Quality for investigation</p> <p>As per P/P QR 1.01, the Clinical Quality Review Nurse will notify member Services of each concern so that a letter can be processed to inform the member that the QOC are investigated and corrective action taken as appropriate; the plan should ensure that when cases are referred to Quality or other departments, documentation of member notification of resolution is generated and included in the tracking system</p> <p><b>PHP Response:</b> For any quality of care issue that is documented within Member Services and</p>	Substantial	<p>Letters to members regarding grievance resolution are checked for readability with a Health Literacy Advisor.</p> <p><b>Recommendation for PHP</b> It was not always clear from the file review that members were informed of the outcome of the investigation.</p>	<p><b>MCO Response:</b> Policy MS 16.0 has been updated and per the policy: (See attached).</p> <ul style="list-style-type: none"> <li>•The Special Support Technician will mail a resolution letter to the Member upon resolution of the grievance. This resolution letter may not take the place of the acknowledgement letter, 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:               <ol style="list-style-type: none"> <li>1.Information considered in investigating the grievances;</li> <li>2.Findings and conclusions based on the investigation; and</li> <li>3. The disposition of the grievance.</li> </ol> </li> </ul> <p>This information is stored and housed in</p>



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	<p>forwarded to Quality, a letter is generated. The letter advises the member their issues will be investigated. Any findings will be used in the ongoing review of provider performance. However, it is not currently documented within EXP that the letter was sent. Management will notify the technicians when letter is generated so it can be placed in EXP.</p> <p><b>IPRO Comments:</b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>			<p>each grievance record.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>
<p>The Contractor shall dispose of each Grievance and provide notice as expeditiously as the Member's health condition requires. <b><i>Any written responses shall be provided within ninety (90) days following the initial filing of the Grievance.</i></b></p>	<p><b>Recommendation for PHP</b> Forty-four of 45 member grievance cases reviewed were resolved within 90 days of the initial filing of the grievance</p> <p>One case did not include documentation of the date of written notification, and for three other cases there was no clear documentation of member notification</p> <p><b>PHP Response:</b> Any quality of care issue that is documented within Member Services and</p>	Full	<p>All 35 cases reviewed were resolved within the 90 day timeframe.</p>	



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	<p>forwarded to Quality a letter is generated. The letter advises their issues will be investigated. Any findings will be used in the ongoing review of provider performance. However, it is not currently documented within EXP that the letter was sent. Management will notify the technicians when letter is generated so it can be placed within EXP.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
<b>7.2.2 Appeals</b>				
Appeals are requests for a review of Action taken by Contractor. Any Member shall have the right to file an Appeal with the Contractor or the Department if he or she disagrees with an Action taken by the Contractor. If a Member does not agree with Action taken regarding an eligibility matter, the Appeal shall be filed with the Department for Community Based Services.				
<b>7.2.2.1 Contractor Appeals Process</b>				
The Contractor shall have a timely and organized system with written policies and procedures for responding to				



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and resolving Appeals by Members. This process shall conform to 42 CFR 438 Subpart F, and 42 CFR 431, as well as other applicable federal and state requirements.				
<b>7.2.2.2 Appeal Policies and Procedures</b>				
(a) All Appeals shall be submitted in writing within thirty (30) days of the aggrieved occurrence, either by the Member or Member's authorized representative, or a Provider acting on behalf of a member with the Member's written consent;		Full	P/P CP5.11 Pre-service Appeals Policy states that all appeals must be filed within 30-calendar days of the date of a notice of an action by the Plan. Appeal requests must be in writing and initiated by the members / authorized representative.	
(b) The Contractor shall respond in writing within three (3) business days to the Member filing the Appeal, and the name and phone number of the staff member who may be contacted about progress in resolving the Appeal;		Full	P/P MS 24.0 includes a 3 day timeframe for written response to the member filing the appeal.	
(c) The Contractor shall provide an explanation regarding the continuation of services pending resolution of an Appeal, if applicable;		Full	P/P CPS.11 states that "If a member request is made for continuation of services during the appeal process and the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment ordered by an authorized provider and the authorization period has not expired, a letter is sent to the member advising that the continuation has been granted and will continue..."	



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(d) The Contractor shall continue to provide benefits for the Member's services if:				
1. The Appeal is filed timely, meaning on or before the later of the following:				
a. Within ten (10) days of the Contractor mailing the notice; and b. The intended effective date of the Contractor's proposed action.		Full	P/P CP5.11 states that PHP "must continue the member's benefits, where applicable, if: The appeal is filed timely, meaning on or before the later of the following: Within 10-days of the MCO mailing the notice of action, except the period of advanced notice is shortened to 5-days if member fraud or abuse has been determined and the intended effective date of the MCO proposed action."	
2. The Appeal involves the termination, suspension or reduction of a previously authorized course of treatment;		Full	Addressed in P/P CP5.11.	
3. The services were ordered by an authorized provider;		Full	Addressed in P/P CP5.11.	
4. The authorization period has not expired; and		Full	Addressed in P/P CP5.11.	
5. The Member requests extension of benefits.		Full	Addressed in P/P CP5.11.	
(e) If the Contractor continues or reinstates the Member's services while an Appeal is pending, the services must continue until one of the following occurs:				



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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
1. The Member withdraws the Appeal;		Full	Addressed in P/P CP5.11.	
2. The Member does not request a state hearing within ten (10) days from the date when the Contractor mails notice of an adverse decision;		Full	Addressed in P/P CP5.11.	
3. A state hearing decision adverse to the Member is made; or		Full	Addressed in P/P CP5.11.	
4. The authorization expires or authorization service limits are met.		Full	Addressed in P/P CP5.11.	
(f) The Contractor shall include provisions for notifying Members of the right to Appeal the Contractor's disposition of an Appeal to the state hearing process, including expedited timeframes;		Full	Addressed in P/P CP5.11.	
(g) Expedited appeals relating to matters which could place the Member at risk or which could seriously jeopardize the Member's health or well being shall be resolved within three (3) business days.		Full	Addressed in P/P CP5.11.	
(h) The Contractor shall allow the Member and/or the Member's authorized representative opportunity before and during the Appeal process, to examine the Member's Appeals case file, including medical records and any other documents.	<b>Recommendation for PHP</b> P/P MS 24.0 indicates that the member or member representative with written consent may examine the case file before and during the appeal; the Member Handbook notes that the member can request documents related to their appeal	Full	A revised appeal acknowledgement letter template (Attachment 5.11E to CP5.11) includes language that members may receive copies of any documents related to appeal.	



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	<p>The member appeal cases that were reviewed only included this information in the resolution letter sent when the appeal process was completed; none of the ten cases reviewed informed the member and/or the member's representative of their ability to examine case file documents and records before and during the appeal process in the acknowledgement letter; this information was not included in the determination letter or acknowledgment letter, only the resolution notice</p> <p>A revised appeal acknowledgement letter template provided onsite included language that members may receive copies of any documents related to appeal if they are requested in writing; this letter appears to have been updated subsequent to last year's review, and should be reflected in next year's review</p> <p>No cases were compliant. PHP should include language regarding the member's right to view all records related to appeal in the initial acknowledgement letter, so that the member is aware of this right at the beginning of the appeal process, and so</p>			



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	<p>that PHP is compliant with DMS contract requirements.</p> <p><b>PHP Response:</b> PHP agrees with the IPRO finding. PHP has updated all applicable policies and corrected appeal acknowledgement letter to include the information regarding the member and/or member's representative's right to view all records related to appeal. The updated appeal acknowledgement letter has been submitted to DMS for review and approval.</p> <p><b>PHP Response:</b> None</p> <p><b>Substantial Compliance</b></p>			
<p>(i) The Contractor shall include, as parties to the Appeal:</p> <ol style="list-style-type: none"> <li>1. The Member and his or her authorized representative; or</li> <li>2. The legal representative of a deceased Member's estate.</li> </ol>		Substantial	<p>Attachment 5.11B to P/P CP5.11 is a letter template that informs members that they can have someone else present the appeal for them.</p> <p><b>Recommendation for PHP</b> Policy should be updated to include reference to a legal representative acting on behalf of a deceased member's estate.</p>	<p><b>MCO Response:</b> Passport will update Policy CP 5.11 to include reference to a legal representative acting on behalf of a deceased member's estate.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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<b>7.2.2.3 Appeals Resolution Notices</b>				
The Contractor shall provide written notice of the Appeal resolution in a manner to ensure ease of understanding and shall include:				
(a) The results of the resolution process and the date it was completed;				
(b) For Appeals not resolved in favor of the Member:				
1. The right to request a state hearing and how to do so, and				
2. The right to request continuation of benefits, if applicable, while the hearing is pending and how to make the request, and				
3. That if the Contractor action is upheld in a hearing, the Member may be liable for the cost of any continued benefits.				
The written response must be provided within thirty (30) days of the initial filing of the Appeal.				
<b>7.2.3 Grievance and Appeal Reporting Requirements</b>				
The Contractor shall submit to DMS and to the Contractor's QMAC, a quarterly report of all Member Grievances and Appeals and their disposition. The report shall be in a format approved by DMS and shall include		Full	DMS Statutory Report for Appeals is issued quarterly.	



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at least the following information:				
(a) Number of Grievances and Appeals, including expedited appeal requests;	<p><b><u>Recommendation for PHP</u></b> It is possible that there were no expedited appeal requests; the plan should specify in reports that no expedited appeal requests were received if that is the case</p> <p><b><u>PHP Response:</u></b> When necessary, Passport will indicate in its quarterly reports that no expedited appeals were received.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Substantial	<p>DMS Statutory Report for Appeals is issued quarterly. When an expedited appeal was filed, it was noted in the report. However, when there were no expedited appeals for the period of time, notation was not made.</p> <p><b><u>Recommendation for PHP</u></b> PHP should specify in reports that no expedited appeal requests were received if that is the case.</p>	<p><b>MCO Response:</b> Passport Health Plan accepts the recommendation and will specify in reporting, when applicable, that no expedited appeal requests were received.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>
(b) Nature of Grievances and Appeals;		Full	Quarterly reports include the nature of grievances and appeals	
(c) Resolution;		Full	Quarterly reports include the resolution of grievances and appeals	
(d) Timeframe for resolution;		Full	Timeframes for resolution are included in quarterly reports	
(e) QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals DMS or its contracted agent may conduct reviews or		Full	Quarterly reports include reports of Trends or Problem Areas for appeals and grievances that outline recommendations and activities	



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onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.			planned as a result of analysis of findings.	
<b>7.2.4 State Hearings for Members</b>				
A Member may request a state hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, no later than thirty (30) days of the final decision by the Contractor. The Department will notify the Member acknowledging receipt of the request and the scheduled hearing date. An impartial State hearing officer will preside over the hearing. Filing or resolving an Appeal through the Contractor's Appeal process is not a prerequisite to obtaining a State hearing through the Department. The State hearing process does not apply to Grievances.		Full	The right of members to request a State hearing at any time if dissatisfied with any action taken by the plan is outlined in P/P CP5.11 and language stating the right to a State hearing was seen in sample letters to members.	
All documents supporting the Contractor's Action must be received by DMS no later than five (5) days from the date the Contractor receives notice from the Department that a 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. DMS 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.	<b>Recommendation for PHP</b> The documents that the plan provided do not appear to reference the requirement that documents that support the action must be received by DMS within 5 days from the date of notice of hearing; the plan should consider including this in policy; none of the reviewed cases included documentation of State hearing request	Full	PHP policies, including CP27.0 include language that the member or member representative with written consent may examine the case file before and during the appeal.  P/P CP27.0 states that In the event a member elects a State Administrative Hearing, DMS Administrative Hearings Branch notifies the	



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	<p><b>PHP Response:</b> None</p> <p><b>Substantial Compliance</b></p>		<p>Passport Appeals Coordinator of the appeal request...: The file and all internal appeal records are sent by secure email to the DMS Administrative Hearings Branch within five calendar days of receipt of notice from the DMS that a Hearing has been filed.</p>	
<p>Failure of the Contractor to comply with the 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.</p>		NA	<p>There were no cases reviewed that involved State hearings.</p>	
<p>In cases other than expedited reviews, the hearing officer shall issue a final written decision to the Member within thirty (30) days of the hearing date. If the individual is dissatisfied with the final decision, he or she may appeal to a court of law to the extent provided under state and federal applicable law.</p>		Full	<p>PHP appeal decision letters include information that the plan must follow the State hearing decision.</p>	
<b>6.6 Provider Appeals</b>				
<p>The Contractor shall implement a process to ensure that all Appeals from Providers are reviewed.</p>				
<p>Every Appeal filed must be recorded in a written record and logged with the following details:</p>				
<p>date,</p>				



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nature of Appeal,				
identification of the individual filing the Appeal,				
identification of the individual recording the Appeal,				
disposition of the Appeal,				
corrective action required, and				
date resolved.				
All Appeals filed by Providers must be in writing and reviewed by the Contractor.				
The Contractor's Appeals process is to be in accordance with procedures found in 907 KAR 1:671, Conditions of Medicaid Provider Participation; Withholding Overpayments; Appeals Process, and Sanctions.				
The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance.				
The Contractor shall monitor and evaluate Provider Grievances and Appeals.				
The Contractor shall submit quarterly reports to the Department regarding the number, type and outcomes of Provider Grievances and Appeals.				



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**Scoring Grid:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	43	7	3	0
Total Points	129	14	3	0

**Overall Compliance Determination:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Range	<b>3.0</b>	<b>2.0 – 2.99</b>	<b>1.0 – 1.99</b>	<b>0 – 0.99</b>
Points Average		<b>146/53=2.75</b>		

**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



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Suggested Evidence**

**Documents**

Policies/procedures for:

- Grievances
- Appeals
- State hearings

Description of committee(s) responsible for the review of quality of care (QOC) issues

QI Committee minutes or other documentation demonstrating investigation evaluation, analysis and follow-up of aggregated grievance and appeal data (may be in conjunction with other member satisfaction data such as CAHPS)

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



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■ = Not Subject to Review

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<b>1.3.3 Delegations of Authority</b>			<p>PHP utilized 12 subcontractors during the review period.</p> <p>AmeriHealth HMO (family planning)</p> <p>AmeriHealth Mercy Health Plan (TPA-claims payment service and administrative support)</p> <p>Avesis Third Party Administrators, LLC (utilization management for dental services). Initiated 10/1/12.</p> <p>Block Vision (vision care)</p> <p>Louisville Metro Health Department (LMHD) (family planning). Terminated 6/6/12.</p> <p>Managed Care of North America (dental care). Terminated 9/30/12.</p> <p>McKesson Health Solutions (24 hour nurse line). Initiated 9/1/12.</p> <p>MedSolutions (utilization management for radiology). Initiated 10/1/12.</p> <p>PerformRx (pharmacy benefit manager)</p> <p>SironaHealth (24 hour nurse line). Terminated 8/31/12.</p>	



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			University of Louisville Physicians (ULP) – formerly UPA Services (provider credentialing)  TC <sup>3</sup> Health (fraud, waste and abuse detection and prevention)  NOTES: CONTRACTS FOR 10 SUBCONTRACTORS REVIEWED.  Avesis contract (Administrative Services Agreement) contained in a damaged file – unable to open.  SironaHealth contract not found with submitted documents.	
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 Section 1.7, Contractor agrees to the following provisions.				
(a) There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.				
(b) Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.				
(c) The Contractor shall monitor the Subcontractor's				



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performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.				
(d) If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.				
(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.	<p><b><u>Recommendation for PHP</u></b>            The AmeriHealth HMO contract should be amended to include this provision</p> <p><b><u>PHP Response:</u></b>            Passport Health Plan owns the family planning provider network and therefore the power to terminate the provider resides with Passport, and has not been delegated to AmeriHealth HMO. However, we will amend the family planning contract (or include in the new contract) the right to terminate providers to the extent that Family Planning owns the network to address this requirement should Passport ever delegate this responsibility to the Family Planning delegate in the future.</p> <p><b><u>IPRO Comments:</u></b>            No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>9 of 12 contracts compliant.</p> <p>Memorandum of Understanding (MOU) with LMHD (terminated 6/6/12) did not contain this provision.</p> <p>Contracts with Avesis and SironaHealth unavailable for review.</p> <p><b><u>Recommendation for PHP</u></b>            PHP should ensure that contracts include required provisions. All subcontracts should be provided for review.</p>	<p><b>MCO Response:</b> Disagree with recommendation for the following reasons:</p> <p><b><u>LMHD MOU:</u></b>            Note applicable - LMHD's scope of delegated services did not include selection of providers.</p> <p>Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance as follows:</p> <p><b><u>AVESIS:</u></b>            Avesis contract, approved by DMS, complies. Passport owns the dental provider network. Contract language is included in In the Avesis Administrative Services Agreement, Schedule D-2 Provider Credentialing/Re-Credentialing, section 6 for this provision for the scope of services delegated.</p>



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				<p><u>SIRONAHEALTH:</u> Not applicable. Sirona's scope of delegated services did not include selection of providers.</p> <p><b>IPRO Comments:</b> Review determination changed to Full. Requirement does not apply to LMHD and SironaHealth. Avesis contract language compliant.</p>
<b>1.7 Subcontracts</b>				
<b>1.7.1 Subcontractor Indemnity</b>				
Except as otherwise provided in this Contract, all subcontracts between the Contractor and its non-physician 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 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				



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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.				
<b>1.7.2 Requirements</b>				
The Contractor may, with the approval of the Department, enter into Subcontracts for the performance of its administrative functions or the provision of various Covered Services to Members. All Subcontractors must be eligible for participation in the Medicaid Program as applicable. The Contractor shall submit for review to the Department each subcontract or contract prior to signing. The Department may approve, approve with modification, or deny subcontracts under this contract with cause if the subcontract does not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a subcontract, the Department may consider such factors as it deems appropriate to protect the State and Members, including but not limited to, the proposed subcontractor's past performance. Each Subcontract, and any amendment to an approved Subcontract, shall be in writing, and in form and content approved by the Department. In the event Contractor has not reached an agreement with Subcontractor within the applicable time frame, Contractor shall notify the Department and keep the Department informed of the status of the negotiations until the applicable contract is finalized. In the event the Department has not approved the subcontract prior to the scheduled effective date, Contractor agrees to execute said subcontract contingent				



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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 Subcontracts 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:	<p><b><u>Recommendation for PHP</u></b>            PHP should ensure that all contracts with subcontractors address all required provisions, in particular, the subcontracts with AmeriHealth HMO and Sirona Health should be amended to include the provisions noted as missing</p> <p><b><u>PHP Response:</u></b>            As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreements to ensure all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>IPRO Comments:</u></b>            No change in review determination.</p> <p><b>Minimal Compliance</b></p>	Substantial	Requirement-specific findings are noted below.	
(a) Identify the population covered by the Subcontract;				
(b) Specify the amount, duration and scope of services to				



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be provided by the Subcontractor;				
(c) Specify procedures and criteria for extension, renegotiation, and termination;				
(d) Specify that Subcontractors use only Medicaid providers in accordance with this Contract;	<p><b><u>Recommendation for PHP</u></b> The AmeriHealth HMO contract should specify that only Medicaid providers will be used for providing family planning services</p> <p><b><u>PHP Response:</u></b> Passport Health Plan owns the provider network and is responsible for ensuring that only Medicaid providers are used. Consequently, while Passport remains responsible for Family Planning provider contracting, we will add this provision to the Family Planning contract to ensure that we are compliant should this duty ever be delegated.</p> <p><b><u>I PRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>8 of 12 contracts compliant.</p> <p>Contract with AmeriHealth does not contain this provision.</p> <p>Contract with MedSolutions does not contain this provision.</p> <p>Contracts with Avesis and SironaHealth were not provided for review.</p> <p><b><u>Recommendation for PHP</u></b> The AmeriHealth HMO and MedSolutions contracts should be amended to include this requirement. Contracts for all subcontractors should be provided for review.</p>	<p><b>MCO Response:</b> Disagree with recommendation for the following:</p> <p><b><u>AMERIHEALTH:</u></b> Not applicable. AmeriHealth's scope of delegated services does not include selection of providers.</p> <p><b><u>MEDSOLUTIONS:</u></b> Not applicable. MedSolution's scope of delegated services does not include selection of providers.</p> <p>Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p> <p><b><u>AVESIS:</u></b> Avesis' contract language is located in Schedule B DMS Addendum, section 2.</p> <p><b><u>SIRONAHEALTH:</u></b> Not applicable. SironaHealth's scope of</p>



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				delegated services does not include selection of providers.  <b>IPRO Comments:</b> Review determination changed to Full. Requirement does not apply to AmeriHealth, SironaHealth or MedSolutions. Avesis contract language is compliant.
(e) Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;				
(f) Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;				
(g) Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	<p><b><u>Recommendation for PHP</u></b> The AmeriHealth HMO contract should be amended to include this requirement</p> <p><b><u>PHP Response:</u></b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p>	Substantial	<p>9 of 12 contracts compliant.</p> <p>Contract with MedSolutions does not contain this provision.</p> <p>Contracts with Avesis and SironaHealth not provided.</p> <p><b><u>Recommendation for PHP</u></b> The MedSolutions contract should be amended to include this requirement. Contracts for all subcontractors should be provided for review.</p>	<p><b>MCO Response:</b> Disagree with recommendation for MedSolution for the following reason:</p> <p><b><u>MEDSOLUTIONS:</u></b> MedSolutions' contract includes this provision in Exhibit A Kentucky DMS Required Provisions Section 13.</p> <p>Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p>



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	<b>Substantial Compliance</b>			<p><u>AVESIS:</u> Avesis' contract language is located in Schedule B DMS Addendum, section 2.</p> <p><u>SIRONAHEALTH:</u> SironaHealth's contract did not contain this provision. Contract terminated 8/31/12.</p> <p><b>IPRO Comments:</b> No change in review determination. Avesis and MedSolutions contract language compliant. SironaHealth contract did not include this requirement.</p>
(h) Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	<p><b><u>Recommendation for PHP</u></b> The Sirona Health contract should be amended to include this provision</p> <p><b><u>PHP Response:</u></b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p>	Substantial	<p>8 of 12 contracts compliant.</p> <p>Contract with TC<sup>3</sup> does not contain this provision.</p> <p>Contract with ULP does not contain the full provision. P.7, N. 5.2. Subcontracting states "Delegated Entity shall not subdelegate, in whole or in part, any functions delegated under this agreement without AMHP's and HMO's express prior written consent." Language does not include DMS.</p> <p>Contracts with Avesis and SironaHealth not provided.</p> <p><b><u>Recommendation for PHP</u></b></p>	<p><b><u>MCO Response:</u></b> Disagree with recommendation for TC3 for the following reason:</p> <p><b><u>TC3:</u></b> TC3's contract language is located in Addendum 2 to the Master Service Agreement, Section 4 Assignment.</p> <p>Agree with recommendation for ULP:</p> <p><b><u>ULP:</u></b> It is not feasible, at this time, for Passport to amend this contract. ULP is currently providing run-out services; the ULP contract terminates July 15, 2013</p> <p>Passport was not notified that the auditor</p>



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	<b>Substantial Compliance</b>		The TC <sup>3</sup> contract should be amended to include this provision. The contract with ULP should be amended to include the full provision. Contracts with all subcontractors should be provided for review.	was unable to open the Avesis files and did not have the opportunity to resubmit.  Contracts with Avesis & SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.  <u>AVESIS:</u> Avesis' contract language is located in Schedule B DMS Addendum, section 31 Assignment.  <b>IPRO Comments:</b> No change in review determination. TC3 and Avesis contracts are compliant. ULP contract does not include this requirement.
(i) Contain an explicit provision that the Department is the intended third-party beneficiary of the Subcontract and, as such, the Department is entitled to all remedies entitled to third-party beneficiaries under law;	<p><b>Recommendation for PHP</b> The Sirona Health should be amended to include this provision</p> <p><b>PHP Response:</b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b>IPRO Comments:</b></p>	Substantial	10 of 12 contracts compliant. Contracts with Avesis and SironaHealth not provided.  <b>Recommendation for PHP</b> All subcontractor contracts should be provided for review.	<p><b>MCO Response:</b> Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p> <p><u>AVESIS:</u> Avesis' contract language is located in Schedule B DMS Addendum, section 32 Third Party Beneficiary.</p> <p><u>SIRONAHEALTH:</u></p>



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	<p>No change in review determination.</p> <p><b>Substantial Compliance</b></p>			<p>SironaHealth's contract did not contain this provision. Sirona's contract terminated 8/31/12.</p> <p><b>IPRO Comments:</b> No change in review determination. Avesis contract includes this requirement. SironaHealth contract does not include this requirement.</p>
<p>(j) Specify that Subcontractor 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;</p>	<p><b>Recommendation for PHP</b> The AmeriHealth HMO contract should be amended to address the submission of encounter records that meet DMS specifications</p> <p><b>PHP Response:</b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b>IPRO Comments:</b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>10 of 12 contracts compliant.</p> <p>Contracts with Avesis and SironaHealth not provided.</p> <p><b>Recommendation for PHP</b> All subcontractor contracts should be provided for review.</p>	<p><b>MCO Response:</b> Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p> <p><b>AVESIS:</b> Avesis' contract language is located in Schedule B DMS Addendum, section 12 Encounter Data.</p> <p><b>SIRONAHEALTH:</b> Not applicable. SironaHealth's scope of delegated services did not include claims and encounter administration.</p> <p><b>IPRO Comments:</b> Review determination changed to Full. This requirement does not apply to SironaHealth. Avesis contract is compliant.</p>



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(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,	<p><b><u>Recommendation for PHP</u></b> Sub-requirement-specific findings are noted below</p> <p><b><u>PHP Response:</u></b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of the Department, and all standards governing the provision of Covered Services and information to Members,				
all QAPI requirements,				
all record keeping and reporting requirements,				
all obligations to maintain the confidentiality of information,				
all rights of the Department, the Office of the Inspector	<b><u>Recommendation for PHP</u></b>	Substantial	10 of 12 contracts compliant.	<b>MCO Response:</b> Passport was not



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General, the Attorney General and other authorized Federal and Commonwealth agents to inspect, investigate, monitor and audit operations,	<p>The Sirona Health contract should be amended to include this provision</p> <p><b><u>PHP Response:</u></b>            As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>I PRO Comments:</u></b>            No change in review determination.</p> <p><b>Substantial Compliance</b></p>		<p>Contracts with Avesis and SironaHealth not provided.</p> <p><b><u>Recommendation for PHP</u></b>            All subcontractor contracts should be provided for review.</p>	<p>notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p> <p><b><u>AVESIS:</u></b>            DMS approved contract. Avesis' contract language is located in Schedule B DMS Addendum, section 29 Medicaid Contract.</p> <p><b><u>SIRONAHEALTH:</u></b>            SironaHealth's contract did not contain this provision. Contract terminated 8/31/12.</p> <p><b><u>I PRO Comments:</u></b> No change in review determination. Avesis contract is compliant. SironaHealth contract does not include this requirement.</p>
all indemnification and insurance requirements, and				
all obligations upon termination;				
(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				



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schedule consistent with industry standards, but no less than annually;				
(m) A subcontractor with NCQA accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	<p>Contract with Block Vision did not include this provision; Block Vision is not accredited but the provision should be included in the contract</p> <p>Contract with MCNA did not include this provision, unable to determine whether MCNA is accredited</p> <p>Contract with AmeriHealth HMO did not include this provision; unable to determine whether AmeriHealth HMO is accredited</p> <p><b><u>Recommendation for PHP</u></b> PHP should ensure that all subcontracts include this provision regardless of whether the entity is accredited; PHP should confirm the accreditation status of each of their subcontractors</p> <p><b><u>PHP Response:</u></b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>IPRO Comments:</u></b></p>	Substantial	<p>6 of 12 contracts fully compliant.</p> <p>MOU with LMHD (terminated 6/6/12) did not include this provision.</p> <p>Contract with MCNA (terminated 9/30/12) did not include this provision.</p> <p>Contract with McKesson Health Solutions does not contain the full provision. Exhibit 1, P. 3, N. 12 states "McKesson shall provide Passport with a copy of its current certificate of accreditation." Language does not include survey report.</p> <p>Contract with PerformRx does not contain the full provision. Second Amendment to the Service Agreement, P. 5, N. 22, states "If PerformRX is NCQA or URAC accredited, PerformRX shall provide Passport with a copy of its current certificate of accreditation upon request of Passport." Language does not include survey report.</p> <p>Contracts with Avesis and SironaHealth not provided.</p> <p>Independent of whether or not the full provision was contained in the contract,</p>	<p><b>MCO Response:</b> Partially to the recommendation for the following reasons:</p> <p>This provision is directly applicable to only those contracts with subcontractors with NCQA accreditation. Historically, and has been approved by DMS in the past and reviewed without non-compliance finding in the past by IPRO, this provision was not included in Passport's contracts unless the subcontractor was NCQA accredited. In 2012, this provision was included as a standard provision in our DMS Addendum template developed in 2012 and approved by DMS.</p> <p><b><u>LMHD:</u></b> Not applicable. LMHD is not NCQA certified for claims and would not be subject to this provision.</p> <p><b><u>MCNA:</u></b> MCNA's contract did not contain this provision. Contract terminated 9/30/12.</p> <p><b><u>MCKESSON:</u></b> McKesson's contract will be amended to include requirement for subcontractor to provide a copy of the survey report.</p>



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	<p>No change in review determination.</p> <p><b>Minimal Compliance</b></p>		<p>delegates submitted a variety of certifications, overall scores, and survey reports:</p> <p>MCNA – certificate/overall score.            McKesson – certificates/overall score.            MedSolutions – certificates only.            PerformRX – certificate/summary report.            ULP – certificates/full report.</p> <p><b><u>Corrective Action Plan</u></b>            In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), 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><b><u>PERFORMRX:</u></b>            PerformRX's contract awaits execution 6/21/13 to amend this requirement for subcontractor to provide a copy of the survey report.</p> <p>Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p> <p><b><u>AVESIS:</u></b>            Avesis' contract language is located in Schedule B DMS Addendum, section 11 NCQA/URAC Accreditation.</p> <p><b><u>SIRONAHEALTH:</u></b>            Not applicable. SironaHealth is not NCQA certified.</p> <p><b><u>DMS Addendum:</u></b>            Passport's DMS Addendum, previously approved by DMS, will be revised and resubmitted to DMS for approval to include the requirement for a copy of the survey.</p> <p><b>IPRO Comments:</b> Review determination</p>



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				changed to Substantial. Requirement does not apply to LMHD or SironaHealth. MCNA, McKesson and PerformRx contracts do not include this requirement. Avesis contract is compliant.
<p>(n) Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.</p>	<p><b>Recommendation for PHP</b> The AmeriHealth HMO contract should be amended to include this provision</p> <p><b>PHP Response:</b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b>IPRO Comments:</b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	<p>Substantial</p>	<p>9 of 12 contracts compliant.</p> <p>Contract with TC<sup>3</sup> does not contain this provision.</p> <p>Contracts with Avesis and SironaHealth not provided.</p> <p><b>Recommendation for PHP</b> The TC<sup>3</sup> contract should be amended to include this provision. Contracts for all subcontractors should be provided for review.</p>	<p><b>MCO Response:</b> Disagree with this recommendation for the following reason:</p> <p><b>TC3:</b> This contract was approved by DMS. TC3's contract fully incorporates the DMS Contract by reference in Addendum 2 of the Master Services Agreement, Section 7.</p> <p>Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p> <p><b>AVESIS:</b> Avesis' contract language is located in Schedule B DMS Addendum, section 25 Requirements for Corrective Action as well as multiple other locations within the Administrative Services Agreement.</p>



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				<p><u>SIRONAHEALTH:</u> SironaHealth's contract language is located in Exhibit A Call Center Services Description Section 5 Corrective Actions.</p> <p><b>IPRO Comments:</b> No change in review determination. Avesis and SironaHealth contracts address this requirement. TC3 contract should include this requirement in specific terms.</p>
(o) The remedies up to, and including, revocation of the subcontract available to the Contractor if the subcontractor does not fulfill its obligations.				
(p) Contain provisions that suspected fraud and abuse be reported to the contractor.	<p><b><u>Recommendation for PHP</u></b> The AmeriHealth HMO contract should be amended to include this provision</p> <p><b><u>PHP Response:</u></b> As part of the contract review process, the delegation oversight team has reviewed each of the subcontractor agreement to ensure that all elements of the DMS contract relevant to delegation oversight are captured. Any contract with missing or substandard language is being amended to include all necessary information in order to ensure that the DMS requirement is met.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Full	<p>9 of 12 contracts compliant.</p> <p>Contract with MedSolutions does not contain this provision.</p> <p>Contracts with Avesis and SironaHealth not provided.</p> <p><b><u>Recommendation for PHP</u></b> The MedSolutions contract should be amended to include this provision. Contracts for all subcontractors should be provided for review.</p>	<p><b>MCO Response:</b> Disagree with this recommendation for the following reason:</p> <p><u>MEDSOLUTIONS:</u> MedSolutions' contract language is located in Exhibit A Kentucky Department of Medicaid Services Required Provisions, Section 24 Reporting Obligations.</p> <p>Passport was not notified that the auditor was unable to open the Avesis files and did not have the opportunity to resubmit.</p> <p>Contracts with Avesis &amp; SironaHealth were submitted 6/20/13. A review by Passport of these contracts confirms compliance for Avesis.</p>



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				<p><u>AVESIS:</u> Avesis' contract language is located in Schedule B DMS Addendum, section 26 Reporting Obligations.</p> <p><u>SIRONAHEALTH:</u> SironaHealth's contract language is located in the Outsource Service Agreement Section 13 Legal Compliance (c).</p> <p><b>IPRO Comments:</b> Review determination changed to Full. Contracts with Avesis, SironaHealth and MedSolutions include this requirement.</p>
<b>1.7.3 Disclosure of Subcontractors</b>				
The Contractor shall inform the Department of any Subcontractor which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of \$25,000 or five percent (5%) of the Subcontractor's operating expense.				
<b>10.5 Management Reports</b>				
Managerial reports demonstrate compliance with operational requirements of the contract. These reports shall include, but not be limited to, information on such topics as... (g) Delegation oversight activities...				



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**Scoring Grid:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	4	7	0	0
Total Points	12	14	0	0

**Overall Compliance Determination:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	<b>3.0</b>	<b>2.0 – 2.99</b>	<b>1.0 – 1.99</b>	<b>0 – 0.99</b>
Points Average		<b>26/11=2.36</b>		

**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



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

**Documents**

- List of delegated entities including type(s) of services provided and date of initial delegation
- Contract with each delegated entity
- Accreditation certificate and report for delegated entities
- Policies and procedures for delegation oversight
- Delegation Oversight Committee description and minutes
- Documentation of ongoing oversight of delegated entities including follow-up
- List of delegated entities terminated during the period of review
- Evidence of DMS notification of all new delegated entities and terminated delegated entities

**Reports**

- Pre-delegation evaluation report for new delegated entities
- Periodic, formal evaluation reports for each delegated entity, including those with accreditation, no less than annually
- Subcontractor certificate of accreditation and survey report
- Statutory Reports



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■ = Not Subject to Review

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<b>1.1 Definitions</b>				
<i>Care Coordination</i> 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 (a) provided by a care coordinator for each Member, (b) supervised by individuals with the equivalent training and experience of a person with an RN nursing degree and experience with disabled persons, or a certified social worker with a medical background, or a nurse practitioner. Care coordination includes:				
(a) Development of the Care Plan				
(b) Coordination of services, including the comprehensive organization of combined medical and social services across a continuum for the greatest benefit to the Member and the most efficient use of resources. This includes arranging for Covered Services and monitoring the provision of Covered Services.				
(c) Care evaluation, including tracking the outcome services and the attainment of Care Plan objectives. Care or Service Plans may be adjusted accordingly.				



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(d) Service management, such as planning, coordination, and evaluation for certain services, without formal Case Management (e.g., arranging for transportation).				
<u>Care Management System</u> includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.				
<u>Care Plan</u> means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
<u>Case Management</u> is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.				
<u>Children with Special Health Care Needs</u> means Members who have or are at increased risk for				



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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 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 programs and expand insurance coverage to additional low-income, uninsured children. Provides general information on the implementation of section 403 of CHIPRA, which applied specific Medicaid managed care requirements in section 1932 of the Act to State CHIP managed care programs.				
<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.				
<b>8.2 Care Coordination/Management Services</b>				
The Contractor shall have programs and processes in				



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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.				
<b>TEXT RELATED TO HEALTH RISK ASSESSMENT OMMITTED INTENTIONALLY – Reviewed under QAPI – Structure and Operations, Health Risk Assessment</b>				
The Contractor shall be responsible for the management and continuity of health care for all Members through the Care Management System.				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.				
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor must have approval from the Department for any subsequent changes prior to implementation of such changes.				



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Care coordination shall be linked to other Contractor systems, such as QI, Member Services and grievances.				
Care Coordination – The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for Members.				
Care coordination is a process to assure that the physical and behavioral health needs of the Medicaid population 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 use the following primary elements for care coordination:				
(a) identify proactively the eligible populations;				
(b) identify proactively the needs of the eligible population;				
(c) provide a designated person to be primarily responsible for coordinating the health services furnished to a specific Member and to serve as primary contact for the Member;				
(d) communicate to the Member the care coordinator's name and how to contact him/her;				
(e) ensure access to a qualified provider who is responsible for developing and implementing a treatment plan, based on the Member's need;				



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(f) ensure the provision of necessary services and actively assist Member and providers in obtaining such services;				
(g) facilitate appropriate coordination between physical and behavioral health services and non-covered services;				
(h) monitor progress of Member to ensure that medically necessary services are received, to assist in resolving identified problems, and to prevent duplication of services;				
(l) ensure access to care coordination for all Medicaid eligible ISHCN, as required by federal regulations;				
At a minimum, the following must be offered:				
(1) A Member who is identified to have special health care needs, chronic diseases or other at risk behaviors shall have a Comprehensive Assessment completed upon admission to Case Management or applicable Disease Management program.				
The Member will be referred to either Case Management or applicable Disease Management program. Guidelines for referral to the appropriate health management programs must be pre-approved by the Department.				
The guidelines will also include the criteria for development of Care Plans.				



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The Care Plan must include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
(2) The Care Coordination Assessment shall:				
Identify facts and recent information and evaluations and include diagnosis and health related services, assessment for co-existing mental health disorders, substance use disorders, physical and mental impairments and medical problems;				
Identify needs, goals, preferences with the member				
Identify demographic information (including ethnicity, education, living situation/housing, legal status, age and developmental factors that influence appropriate outcomes, goals and methods for addressing them)				
Identify the cultural and environmental supports				
Identify the Member's health goals and understanding of options for treatment				
Identify activities of daily living, employment, and indirect support systems.				
The Care Plan shall be developed in consultation with the Member, family and the Member's legal guardian, if appropriate. The care plan shall be based on a comprehensive assessment of the goals, capacities				



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and medical condition of the Member and needs and goals of the family. The Member must be provided an opportunity to provide input. The Contractor shall document Member participation in the Care Plan process, as well as an observation of the Member understands of the Care Plan. Agreement between the Contractor and Member regarding the Care Plan is the desired goal. When there is disagreement, the areas of disagreement, the reasons for disagreement and how the Care Plan will be implemented must be documented in the Care Plan.				
There shall be an evaluation process that measures the Member's response to care and the Contractor shall ensure revision of the plan as needed.				
The Contractor must develop a process to ensure that Member can access information from their Care Plans.				
Each Member shall be allowed to choose his or her Primary Care Provider to the extent reasonable and appropriate. Continuity of care with that Primary Care Provider shall be ensured by scheduling all routine visits with that Primary Care Provider unless the Member requests otherwise in accordance with Section 7.1.7 of this Contract (Second Opinions).				
The Contractor shall provide Case Management and or Disease Management Services for Members.				
Case Management – The Contractor shall have methods /guidelines for identifying persons at risk of,				



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or having, chronic illnesses and physical or developmental disabilities and determining their specific needs. Health care case management shall be provided by the Contractor to Members, as appropriate.				
Case Management is a service that assists Members in gaining access to needed medical, social, educational, and other services and follows a developed care plan developed in conjunction with the Member, family and provider(s). It is designed to identify all care needs to increase timely access to services and resources, promote continuity of care, improve Member's health outcomes and maximize effective, efficient use of resources.				
Case management shall be provided to Members who meet one of more of the following criteria: multiple, often multidisciplinary, providers; technology-dependent; frequent hospitalizations required; high-risk for developing secondary disabilities or co-morbidities; or dually diagnosed, including a diagnosis of mental retardation or mental illness. Members may request case management services and the Contractor must review all Member requests. Medical conditions for which case management is recommended include, but is not limited to:				
<u>Case Management - Children:</u> craniofacial anomalies, cleft lip and palate, myelomeningocele, cerebral palsy, cystic fibrosis, hemophilia, scoliosis, HIV				



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disease, technology-dependent children, autism, mental retardation with related physical disabilities, head injuries/brain trauma, genetic conditions or congenital anomalies with complex treatment regimens, neurological impairments, seizures, severe kidney disease, severe heart defects, failure to thrive, medically-fragile foster children				
<b>Case Management - Adults:</b> Developmental disabilities, mental retardation, diabetes, HIV disease, technology-dependent adults, functional disabilities post-CVA, persons with chronic illnesses who live alone, Alzheimer's disease and related disorders, Chronic heart disease, Chronic renal disease, Chronic lung disease, high-risk pregnancy, uncontrolled hypertension with complicated medications and/or treatment regimen, severe visual impairment or blindness, cerebral palsy, cystic fibrosis, hemophilia.				
The Contractor shall:				
(a) Develop protocols describing the Contractors case management services and minimum qualification requirements for case management staff;				
(b) Develop and implement policies and procedures for monitoring effectiveness of case management based on patient outcomes;				



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(c) Develop and implement policy and procedure for monitoring service utilization including ER visits and hospitalizations, with adjustment of severity of patient conditions;				
(d) Provide regular information to providers and Members on the case management services available and the criteria for referring Members.				
The Contractor shall have methods /guidelines for determining which members are in need of case management services, including establishment of severity thresholds, and methods for identification of members including monitoring of hospitalizations, pharmacy and ER usage, provider referrals, new member health risk screenings and self-referrals.				
The Contractor shall have guidelines for determining the specific needs of members in case management, including specialist referrals, DME, home health services, self-management education, etc.				
Disease Management – The Contractor shall develop and implement integrated treatment approaches/programs that include the collaboration and coordination of patient care delivery systems that focus on measurably improving clinical outcomes for a particular medical condition. Interventions shall include the use of appropriate clinical resources such as preventive care, treatment guidelines, patient counseling and education. It shall also include evaluation of the appropriateness of the scope,				



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setting and level of care in relation to clinical outcomes and the cost of a particular condition.				
The Contractor through its operations shall emphasize continuity of care and its importance to members throughout their enrollment.				
The Contractor shall establish referral relationships with various human service agencies whose services are outside the Contractor's scope of Covered Services, but important to the health of Members. Examples of these services shall include the WIC Supplemental Nutrition Program, Head Start, preschool services for at-risk children, and protective services, among many others.				
<b>8.2.1 Individuals with Special Health Care Needs (ISHCN)</b>				
ISHCN are persons who have or at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services.				
ISHCN 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.				
Identification of ISCHN:				



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As per the requirement of 42 CFR 438.208, DMS 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.				
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.				
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.				
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification);				
Individuals with chronic illness of: diabetes, asthma, HIV, COPD, and Sickle Cell.				
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the				



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member's disease, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.				
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.				
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.				
The Contractor shall develop policies and procedures that consider the needs of the ISHCN.				
The Contractor shall have policies in place that address the coordination between the Contractor and Providers who render Behavioral Health Services to members.				
<b>8.2.2 DCBS Protection &amp; Permanency Clients</b>				
Children in foster care and children receiving adoption assistance are included in Medicaid eligibility categories P, S, and X and in category D (this category includes children in foster care and children receiving adoption assistance who have Supplemental Security Income, as well as all other recipients who have SSI). They may occasionally appear in other eligibility categories. DCBS guardianship clients are also				



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<p>included, along with other recipients who have SSI, in category D.</p>				
<p>Recipients who are foster children, adult guardianship clients, or adoptive children shall be identified as Individuals with Special Health Care Needs and will be enrolled in the Partnership Program through a service plan that will be completed on each such Recipient by DCBS prior to being enrolled with the Contractor. The service plan will be completed by DCBS and forwarded to the Contractor prior to enrollment and will be used by DCBS and the Contractor to determine the individual's medical needs and identify the need for placement in case management.</p>	<p><b>Recommendation for PHP</b>            PHP should ensure that DCBS members have a documented medical history to enable PHP and the DCBS staff to render an informed decision as to whether members would benefit from case management services</p> <p>When the DCBS-completed service plan does not document the member's medical needs, PHP should outreach to the member (or caregiver) to obtain this information and assess the member's need for case management services; all outreach efforts and the results of these efforts should be clearly documented on the DCBS Service Log</p> <p><b>PHP Response:</b>            P/P's CC 5.01, 5.03, and 5.04 have been updated to reflect the process change directed by the DCBS Acting Commissioner and DMS at the meeting held at DMS on February 6, 2012. When the DCBS-completed service plan does not document the member's medical needs, PHP reviews medical claims history and initiates outreach to the DCBS</p>	<p>Full</p>	<p>P/Ps CC 5.01, CC 5.03, and CC 5.04 have been updated to reflect the process change directed by the DCBS Acting Commissioner and DMS at the meeting held on February 6, 2012. In addition, DCBS and PHP collaborated to revise/update the Service Plan form. Per PHP, the plan began receiving these in December 2011.</p> <p><u>DCBS Service Plan Review</u>            Most of the Service Plans reviewed during the onsite review contained documentation of the member's medical needs. In addition, the files and DCBS meeting logs provided evidence of the PHP Foster Care Liaison's (FCL's) review of medical claims history and outreach to the DCBS worker to determine if the member would benefit from case management services and to provide information regarding EPSDT services due and completed.</p> <p>None of the members in the sample required care management, as evidenced in the meeting log documentation. There were no DCBS requests for care</p>	<p><b>DMS Response:</b> DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> <li>▪ review DCBS contract</li> <li>▪ review MCO contract</li> <li>▪ discuss findings with DMS</li> <li>▪ meet with DCBS to discuss their contract scope of work and responsibilities</li> <li>▪ meet with each MCO to discuss their scope of work and contract responsibilities</li> <li>▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans</li> <li>▪ review process for completing the service plans</li> <li>▪ make changes as warranted</li> <li>▪ monitor the progress and if warranted, have additional meetings and amend process.</li> </ul>



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	<p>worker as the child's representative for additional information and to determine if the member would benefit from case management services. "DCBS request for case management "and "Foster Parent contact information" was removed from the Service Plan in December 2011.</p> <p>PHP will confirm with DMS/IPRO during the regular monthly call that this process is agreeable and compliant with contract language.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination. Discussion of this process will be included as a topic for future DMS/IPRO monthly call.</p> <p><b>Substantial Compliance</b></p>		<p>management and all DCBS/PHP determinations of need were documented as "no".</p> <p>PHP indicated that in 2013 the plan has established a care management initiative for DCBS children who are medically fragile. PHP provided some sample 2013 files for medically fragile DCBS children and a tracking log. A brief review of the case files showed evidence of assessment, monitoring, follow-up, linkages, and coordination.</p> <p><b><u>Recommendation for DMS</u></b> 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</p>	



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			<p>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>	
<p>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. DMS will work with DCBS to explore opportunities to increase the accuracy of the enrollment files for members in Foster Care through</p>	<p>File reviews show evidence of approvals for services such as pharmacy, changes in PCP, transportation for the DCBS service plan review sample</p> <p>IPRO also conducted a claims review of DCBS members; all</p>	Minimal	<p><u>DCBS Claims File Review</u></p> <p>The claims files were not available for review at the time of the onsite due to an uploading error on the part of PHP. PHP posted the files to the EQRO's ftp site during the onsite for review post onsite.</p>	<p><b>MCO Response:</b> Passport Health Plan continues to provide and improve ongoing care coordination for members who are foster children, adult guardianship clients, or adoptive children as evidenced by:</p> <ul style="list-style-type: none"> <li>•Ongoing monthly meetings continue with the</li> </ul>



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<b>State Contract Requirements</b> <b>(Federal Regulation: 438.208)</b>	<b>Prior Results &amp; Follow-Up</b>	<b>Review Determination</b>	<b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b>	<b>Health Plan's and DMS' Responses and Plan of Action</b>
<p>the transmission of the correct program code and flag. A monthly report of Foster Care Cases shall be sent to DMS thirty (30) days after the end of each month.</p>	<p>professional/outpatient claims including date of service, CPT codes, diagnosis codes, provider specialty codes, place of service code; documentation of any outreach efforts including outreach related to EPSDT services; DCBS Service Plan; and any case management or care coordination files were requested for each selected member</p> <p>Twenty-five files (20 files plus a 5-file over sample) were selected for review with the following review results:</p> <p>7 member selected had no claims provided for review</p> <p>Of the remaining 19 members, 6 members had evidence of one well-child visit and one member had evidence of 2 well-child visits during the review period; it should be noted that the claims history for these members included coding of comprehensive history and physical exam services codes, such as 99394, but did not include the modifier "EP" indicating that all components of the appropriate EPSDT screening interval having been completed; 12 members had claims for the review period however none of the claims were coded for a well-child visit</p>		<p>No service plans were available/provided. In addition outreach could not be assessed for DCBS clients due to the directive (stated below) that the plan not communicate directly with DCBS members/caregivers. However, documentation of outreach to the DCBS worker including to obtain information about EPSDT services was noted.</p> <p>The DCBS Acting Commissioner directed that the health plan not contact the member/guardian in Foster care, rather to use the DCBS caseworker as the primary care manager and point of contact.</p> <p>Although direct outbound communication with the DCBS member/caregiver was not permitted, the files sometimes contained documentation of inbound communications from caregiver, providers, and case workers. The majority were related to checking eligibility, change of address/phone, requests for ID cards and similar inquiries.</p> <p>Despite the lack of DCBS Service Plans, in the review of the meeting logs it was noted that members were discussed initially at a DCBS/PHP meeting. Evidence of ongoing communication/follow-up</p>	<p>DCBS MCO liaison to review new service plans, discuss and identify members in need of case management services, and make recommendations for follow up. Passport will evaluate the current agenda and meeting logs utilized by the Foster Care/Guardianship/Adoption Assistance Liaison and make revisions to add on-going communication and follow-up to make this clearly evident.</p> <ul style="list-style-type: none"> <li>•Passport's Foster Care/Guardianship/Adoption Assistance Liaison continues to build relationships with MCO Liaisons, benefit workers and case workers in order to improve care coordination for this population.</li> <li>•Active participation in monthly meetings with the DCBS Commissioner's office and/or designee and key Plan staff to discuss issues and ways to improve care coordination for foster children, adult guardianship clients, and adoptive children. Some of the recent discussions have been how to correctly identify this population via membership files, efforts to improve service plan completion, revision of the current service plan utilized by DCBS workers, and how to improve coordination between physical and behavioral health providers.</li> </ul>



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	<p>Per PHP, there were no outreach calls or DCBS Service Plans found related to EPSDT, care coordination or case management for the members in this sample</p> <p>DMS confirmed receipt of monthly reports</p> <p><b>Recommendation for PHP</b> PHP should ensure ongoing care coordination for members with special health care needs including outreach related to EPSDT services</p> <p><b>PHP Response:</b> PHP identifies and outreaches to all non-compliant members regardless of category of aid status. In addition to telephonic outreach, PHP EPSDT department sends a letter to the DCBS worker for those members late or missing a Well Child visit when the Foster Care indicator is on the member demographic file.</p> <p><b>IPRO Comments:</b> No change in review determination. IPRO suggests that PHP discuss with DMS what evidence should be produced to show compliance with this standard. For</p>		<p>discussions at future meetings was not seen in subsequent logs, therefore ongoing care coordination, whether or not a member was enrolled in care management, was not evident.</p> <p>Twenty files were reviewed with the following results:</p> <p>15 of 20 files included evidence of at least one well care visit during the review period.</p> <p>14 of 15 were coded using a 993xx CPT code for EPSDT.</p> <p>Outreach efforts were not evident in the 5 files lacking a well visit.</p> <p>One file contained documentation of coordination between physical and behavioral health.</p> <p><b>Corrective Action Plan</b> In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the</p>	<p>Passport is awaiting a revised service plan from DCBS to be utilized by the DCBS workers and the Foster Care/Guardianship/Adoption Assistance Liaison to improve communication by all parties involved with the member.</p> <p>Passport identifies and outreaches to all members identified as not having an expected well-care visit regardless of category of aid status. Outreach efforts include telephonic outreach and home visits.</p> <p>In addition to the outreach noted above, the EPSDT department sends a letter to the assigned DCBS worker notifying the worker a specific member is in need of a well care visit.</p> <p>Passport delivers to DMS a monthly report identifying all members in foster care and those that are in enrolled in case management, disease management, and have completed a Health Risk Assessment.</p> <p><b>IPRO Comments:</b> No change in review determination.</p> <p><b>DMS Response:</b> DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> <li>▪ review DCBS contract</li> <li>▪ review MCO contract</li> <li>▪ discuss findings with DMS</li> </ul>



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	<p>example, PHP could maintain a listing of members that were contacted due to noncompliance and a copy of the correspondence that was sent. Similarly, contact with the DCBS worker should be documented and retrievable.</p> <p><b>Minimal Compliance</b></p>		<p>MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.</p> <p><b>Recommendation for DMS</b> 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.</p>	<ul style="list-style-type: none"> <li>▪ meet with DCBS to discuss their contract scope of work and responsibilities</li> <li>▪ meet with each MCO to discuss their scope of work and contract responsibilities</li> <li>▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans</li> <li>▪ review process for completing the service plans</li> <li>▪ make changes as warranted</li> <li>▪ monitor the progress and if warranted, have additional meetings and amend process.</li> </ul>



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			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.	
<b>Adult Guardianship Clients</b>				
Upon Enrollment in the Partnership Program, each Guardianship adult shall have a service plan prepared by DCBS. The service plan will indicate DCBS level of responsibility for making medical decisions for each Member. In the event 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.	<p><b>Recommendation for PHP</b> DCBS files should clearly identify whether a member is in need of case management services</p> <p>DCBS service plan files selected for EQRO review should include the case management files for any selected members that have been referred for case management services</p> <p><b>PHP Response:</b> P/P's CC 5.01, 5.03, and 5.04 have been updated to reflect the process change</p>	Full	<p>PHP provided a P/P CC 5.03 Guardianship Case Management Process (original date 7/2009) which is similar to the P/P for managing DCBS children between DCBS and PHP. PHP indicated that in 2013, the plan has begun to work with the DCBS Commissioner on initiatives related to this population. PHP stated that communication has increased and monthly meetings will begin in April.</p> <p>None of the files reviewed indicated the need for case management.</p>	



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	<p>directed by the DCBS Acting Commissioner and DMS at the meeting held at DMS on February 6, 2012. When the DCBS-completed service plan does not document the member's medical needs, PHP reviews medical claims history and initiates outreach to the DCBS worker as the child's representative for additional information and to determine if the member would benefit from case management services. "DCBS request for case management "and "Foster Parent contact information" was removed from the Service Plan in December 2011.</p> <p>PHP will confirm with DMS/IPRO during the regular monthly call that this process is agreeable and compliant with contract language.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination. Discussion of this process will be included as a topic for future DMS/IPRO monthly call.</p> <p><b>Substantial Compliance</b></p>			
<b>Children in Foster Care</b>				
Upon Enrollment in the Partnership Program, each child in Foster Care shall have a service plan prepared		Full	<u>DCBS Service Plan Review</u> None of the members in the Service Plan	<b>DMS Response:</b> DMS agrees with IPRO's recommendation. DMS will:



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<p>by DCBS as required by 907 KAR 1:705, 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 Partnership staff to identify, discuss and resolve the 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>review was noted as requiring care management, as evidenced in the meeting log documentation. There were no DCBS requests for care management and all DCBS/PHP determinations of need were documented as "no".</p> <p><b>Recommendation for DMS</b> 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</p>	<ul style="list-style-type: none"> <li>▪ review DCBS contract</li> <li>▪ review MCO contract</li> <li>▪ discuss findings with DMS</li> <li>▪ meet with DCBS to discuss their contract scope of work and responsibilities</li> <li>▪ meet with each MCO to discuss their scope of work and contract responsibilities</li> <li>▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans</li> <li>▪ review process for completing the service plans</li> <li>▪ make changes as warranted</li> <li>▪ monitor the progress and if warranted, have additional meetings and amend process.</li> </ul>



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			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.	
In the event the 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.	<b>Recommendation for PHP</b> 17 of 20 files reviewed were compliant One file documents contact with foster mother and referrals made to EPSDT and case management however case management file not provided for review; one file and log indicate referral to case management however case management file not provided for review; one file indicates that member currently hospitalized at time of service plan review and DCBS and PHP do not identify need	NA	<b>DCBS Service Plan Review</b> None of the members in the Service Plan review was noted as requiring care management, as evidenced in the meeting log documentation. There were no DCBS requests for care management and all DCBS/PHP determinations of need were documented as "no".	



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	<p>for CM referral, however CHFS out of home care service plan dated 12/15 indicates need for specialized CM services – reviewer is unable to determine whether any interventions were needed or implemented for this member</p> <p><b>PHP Response:</b> P/P's CC 5.01, 5.03, and 5.04 have been updated to reflect the process change directed by the DCBS Acting Commissioner and DMS at the meeting held at DMS on February 6, 2012. When the DCBS-completed service plan does not document the member's medical needs, PHP reviews medical claims history and initiates outreach to the DCBS worker as the child's representative for additional information and to determine if the member would benefit from case management services. "DCBS request for case management "and "Foster Parent contact information" was removed from the Service Plan in December 2011.</p> <p>PHP will confirm with DMS/IPRO during the regular monthly call that this process is agreeable and compliant with contract language.</p>			



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	<p><b>IPRO Comments:</b> No change in review determination. Discussion of this process will be included as a topic for future DMS/IPRO monthly call.</p> <p>PHP response does not address the lack of case management files for the noted cases.</p> <p><b>Substantial Compliance</b></p>			
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	<p><u>DCBS Service Plan Review</u> None of the members in the Service Plan review was noted as requiring care management, as evidenced in the meeting log documentation. There were no DCBS requests for care management and all DCBS/PHP determinations of need were documented as "no".</p>	
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the	<p><b>Recommendation for PHP</b> P/P should be revised to address the process for resolving disagreements about the service plan between the DCBS and PHP staff</p> <p>Service plans agreed to by DCBS and PHP staff should be signed by the respective staff to indicate their agreement</p>	Full	P/P CC 5.01 was updated to reflect the process to be followed when DCBS and PHP cannot reach agreement regarding the need for care management. In addition, this policy includes a list of triggers for care management. The Service Plan form was updated by DCBS and PHP and is in use since December 2011. It contains fields for the signature of each respective staff (DCBS, PHP) to	<p><b>DMS Response:</b> DMS agrees with IPRO's recommendation. DMS will:</p> <ul style="list-style-type: none"> <li>▪ review DCBS contract</li> <li>▪ review MCO contract</li> <li>▪ discuss findings with DMS</li> <li>▪ meet with DCBS to discuss their contract scope of work and responsibilities</li> <li>▪ meet with each MCO to discuss their scope of work and contract responsibilities</li> <li>▪ meet with DCBS, and each MCO to review</li> </ul>



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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><b>PHP Response:</b> Policy CC 5.01 was updated to reflect the recommendation and given to IPRO/DMS during the Onsite visit. Based on the February meeting the cover sheet for the DCBS Service Form is being updated and includes signature for each respective staff to indicate agreement.</p> <p><b>IPRO Comments:</b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>		<p>indicate agreement. The DCBS Service Plan Review cover sheet is being updated based on a meeting held in February 2012. Final version and approval is pending.</p> <p><u>Service Plan File Review</u></p> <p>20 Service Plan Files and corresponding meeting logs were reviewed.</p> <p>20 of 20 contained the DCBS signature</p> <p>20 of 20 contained the PHP signature.</p> <p><b>Recommendation for DMS</b> 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</p>	<p>service plan process and determine what barriers exist to prevent completion of the service plans</p> <ul style="list-style-type: none"> <li>▪ review process for completing the service plans</li> <li>▪ make changes as warranted</li> <li>▪ monitor the progress and if warranted, have additional meetings and amend process.</li> </ul>



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			<p>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>	
<b>Children Receiving Adoption Assistance</b>				
<p>Upon Enrollment in the Partnership Program, each Member receiving adoption assistance shall have a service plan prepared by DCBS as required by 907 KAR 1:705. The process for enrollment of children</p>				



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receiving adoption assistance shall follow that outlined for Children in Foster Care.				
<b>Pediatric Sexual Abuse Examination</b>				
Contractor shall have Providers in its network that has the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the Director of the Division of Family Services within the Department for Community Based Services.				
<b>Coordination of Care</b>				
<p>The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.</p>	<p><b>Recommendation for PHP</b>            PHP should 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 in order to present a comprehensive assessment of services provided to this population</p> <p><b>PHP Response:</b>            PHP will investigate the feasibility of separating the DCBS population's complaints and grievances.</p> <p>Initial process discussions have identified a potential ability to separate DCBS</p>	Minimal	<p>Regarding measuring, tracking, trending, and acting on metrics related to the DCBS population:</p> <p><u>Utilization measures</u>            PHP presented a report of DCBS members' utilization labeled as 7/1/11 – 9/30/11. It is not clear why this period of time was used rather than a more recent time frame. The report included a summary of expenditures, by claim type: Par, Non-Par, ER, Vision, Dental, Pharmacy, and Total. There were also tabs for each claim type. Each tab contained a list of claims. Upon closer review, it was noted that the time frame for the claims varied by type, and does</p>	<p><b>MCO Response:</b> Passport Health Plan strives to ensure all members have access to care and diligently works to resolve any identified barriers to care.</p> <p><u>Utilization measures</u>            The noted report is labeled incorrectly and is a report of DCBS members' utilization for DOS 7-1-11 through 12-31-12. Passport actively monitors utilization trends and works to resolve identified issues. Non-par utilization is tracked by provider type and county. Care Coordination will further analyze available reports by category of aid.</p> <p><u>Access measures</u>            Passport monitors member access to both PCPs and specialists at least quarterly and actively</p>



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	<p>complaints and grievances in the current Member Services application.</p> <p>PHP will investigate and develop a satisfaction survey for care and services specific to DCBS clients and track and trend barriers to care and services.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Non-compliance</b></p>		<p>not match the titles of the reports. The range of dates on the claims reports ran from 2006 – 2012 overall. Claim counts ranged from ~3160 (ER) to &gt; 401,990 (Pharmacy).</p> <p><b><u>Access measures</u></b> PHP indicated that it is capable of using its business reports to evaluate access by a variety of factors, including gender, zip code, category of aid, among others. These reports were not provided.</p> <p><b><u>Complaints and Grievances</u></b> In 2012, PHP stated that it would investigate the feasibility of reporting complaints and grievances for the DCBS population. PHP Indicated that the potential of the existing Member Services application to stratify claims by category of aid/for the DCBS population was examined. PHP described its progress during the onsite visit, but no reports have been produced to date. PHP expects to produce reports in 2013. A Workplan template displaying fields for complaints and grievances by category of eligibility was provided. P/P FC 4.0 Grievance/Complaint Process for DCBS Members was provided (original date:</p>	<p>works to eliminate any access issue identified. The Foster Care/Guardianship/Adoption Assistance Liaison actively works with all DCBS clients to identify providers to ensure access to needed services regardless of residence. In addition, the Foster Care/Guardianship/Adoption Assistance Liaison collaborates with each sub-contractor to ensure access to vision, dental, and behavioral health services regardless of residence.</p> <p><b><u>Complaints and Grievances</u></b> Passport's Member Services Department tracks all complaints and grievances. As a result of the last DMS/IPRO review, Passport reports in the Work plan quarterly, the total number of complaints and grievances, type of complaint/grievance, and a break down by category of aid to include DCBS and Foster Care. At the time of the onsite visit (March 4th and 5th) the first quarter Work plan was not completed; however, a redline version noting the required fields was shared.</p> <p><b><u>Satisfaction with care/services specific to DCBS</u></b> Passport has a DRAFT version of a DCBS survey under internal review. Passport currently utilizes satisfaction surveys to evaluate a member's response to care coordination services and to identify opportunities for improvement. The DRAFT DCBS survey is</p>



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State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>7/2009).</p> <p><u>Satisfaction with care/services specific to DCBS</u></p> <p>In 2012, PHP indicated it would investigate and develop a satisfaction survey for care and services specific to DCBS clients. P/P CC 25.03, labeled "DRAFT" and issued 3/5/2013, describes a satisfaction survey for DCBS clients related to care coordination/care management services. PHP did not implement its corrective action timely.</p> <p>The policy is almost identical to the general satisfaction with care management survey. The survey instrument uses the word "liaison" to refer the PHP staff member who works with the member. This is a complex word not at a 6<sup>th</sup> or 8<sup>th</sup> grade reading level. Also, there are no survey items specifically relevant to the DCBS population. In addition, this survey would not address the general DCBS population, since not all DCBS members are in care management. No results for this survey were provided since PHP was not able to field the survey due to a directive that the health plan was not to have direct</p>	<p>meant to be given to caregivers in order to glean the satisfaction with the Foster Care/Guardianship/Adoption Assistance Liaison. This survey has not been finalized or sent to DMS for review at this time.</p> <p>A general overall population survey of DCBS members was not the understanding of the previous review and has not been developed at this time. DCBS members would be included in the Plan's annual CAHPS survey; however results are not broken down by category of aid.</p> <p>Passport will continue to work with DMS, IPRO and the DCBS Commissioner to develop and implement a survey tool that evaluates satisfaction with care and services.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>communication with DCBS members/caregivers.</p> <p>Based on the current review, PHP has not yet been able to implement this. It is in process and expected to be functional sometime in CY 2013.</p> <p><b>Corrective Action Plan</b>            In accordance with the DMS/MCO contract (provision 5.3, External Quality Review Organization), 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>	
<b>Reporting</b>				
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.				
<b>8.2.5 Pediatric Interface</b>				



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<b>Case Management/Care Coordination/Department for Community Based Services (DCBS) Clients</b> <i>(See Final Page for Suggested Evidence)</i>				
<b>State Contract Requirements</b> <b>(Federal Regulation: 438.208)</b>	<b>Prior Results &amp; Follow-Up</b>	<b>Review Determination</b>	<b>Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</b>	<b>Health Plan's and DMS' Responses and Plan of Action</b>
<p>The Contractor must establish procedures to coordinate care for children receiving school-based services and early intervention 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 are specifically excluded from Contractor coverage.</p>				
<p>School-Based Services are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. 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 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.</p>				
<p>The Contractor shall implement policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient, PRTF or treatment or foster care placement.</p>				
<p>To prevent duplication of services and to promote continuity of care, the Contractor shall be encouraged</p>				



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<b>State Contract Requirements</b> <b>(Federal Regulation: 438.208)</b>	<b>Prior Results &amp; Follow-Up</b>	<b>Review</b> <b>Determination</b>	<b>Comments (Note: For any element that</b> <b>deviates from the requirements, an</b> <b>explanation of the deviation must be</b> <b>documented in the Comments section)</b>	<b>Health Plan's and DMS'</b> <b>Responses and Plan of Action</b>
to sign a Memorandum of Understanding with all school based providers in the Service Area.				
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.				



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

**Scoring Grid:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	4	0	2	0
Total Points	12	0	2	0

**Overall Compliance Determination:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Range	<b>3.0</b>	<b>2.0 – 2.99</b>	<b>1.0 – 1.99</b>	<b>0 – 0.99</b>
Points Average		<b>14/6=2.33</b>		

**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



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

### Documents

Policies/Procedures for:

- Identification of DCBS clients
- Identification of DCBS clients for CM/CC
- Identification of ISHCNs
- Identification of members for case management, disease management and/or care coordination
- Care management system including guidelines for care coordination
- Care coordination including DCBS clients
- Comprehensive Assessment including guidelines for referral to health management programs
- Care Plan including criteria for care plan development and ensuring member access to information in their care plan
- Case management including guidelines for determining specific needs of members in case management
- Monitoring effectiveness of case management
- Monitoring service utilization for case management enrollees
- Disease management
- ISHCN including identification, screening and assessment
- Coordination of care for children receiving school-based services and early intervention services, including coordination of services for children returning to school after extended absences

Case management staff position description

Evidence of dissemination of information to members and providers about availability and referral process for CM/CC/DM programs

Evidence of monitoring effectiveness of case management based on patient outcomes

Evidence of monitoring service utilization for case management

Evidence of referral relationships with human services agencies whose services are outside MCO scope of covered services

Evidence of tracking, analysis, reporting and interventions for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for DCBS population



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Evidence of monitoring of continuity and coordination of care for children receiving school-based services and early intervention services as part of QAPI program

Evidence of tracking and evaluation of clients declining CM/CC services

### File Review

Case management/Care Coordination files for a random sample of cases selected by EQRO (including DCBS/ISHCN clients)

Logs of DCBS/PHP meetings to review members/DCBS clients newly enrolled and annually

DCBS Service Plans for a sample of cases selected by EQRO

Claims records, EPSDT records, care management/care coordination files, member outreach records for a sample of cases selected by EQRO

### Reports

Monthly/quarterly reports of service plan reviews conducted for DCBS clients

Number of DCBS clients enrolled in PHP as of the last day of the review period (June 30, 2012)

Number of DCBS clients enrolled in PHP who are enrolled in case management/care coordination as of the last day of the review period (June 30, 2012)



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**Continuity & Coordination of Care: Behavioral and Physical Health Care  
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State Contract Requirements (Federal Regulation 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<b>9. Behavioral Health Interface</b>				
<b>9.1 Program and Standards</b>				
The Contractor will use its best efforts to coordinate the assessment and treatment for Behavioral Health Services for Members as the Members utilize multiple providers, services sites, and levels of care. Appropriate information sharing and careful monitoring of diagnosis, treatment, follow up and medication usage is especially important when Members use physical and behavioral health systems simultaneously.		Full	Addressed by Complex Case Management (CCM) Program Description 2012, Section X1. Behavioral Health Liaison –access to BH and coordination between BH and physical health.  Addressed by Behavioral Health Liaison Tracking Sheets (by Region, by Member - includes case details).  Addressed by Behavioral Health Liaison Tracking Sheets for BH Referral Form (by Member - includes case details).	
The Contractor shall work proactively and use its best efforts to ensure coordination and continuity of care for physical and Behavioral Health Care services.		Full	Addressed by Complex Case Management (CCM) Program Description 2012, Section X1. Behavioral Health Liaison.	
The Contractor shall provide education to its provider network regarding HIPAA compliant protocols for sharing information between physical health and behavioral health providers.	<b><u>Recommendation for PHP</u></b> The plan should ensure that all providers are aware of the availability of the BH liaison for assistance with referral and coordination of care  <b><u>PHP Response:</u></b> PHP notified all participating providers via letter regarding the availability, responsibilities, and	Full	Language regarding access to a BHL to coordinate care between physical and behavioral health services, utilizing HIPAA protocols, is found in the following formats:  Provider Letter 11/2/11. Posted on website 6/5/12. Medical Office Note 8/13/12. Updates to Provider Manual: 12.4. Behavioral Health and 12.4.1 Behavioral	



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<b>Continuity &amp; Coordination of Care: Behavioral and Physical Health Care</b> <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>how to contact the Behavioral Health Liaison in November 2011. Public Affairs will add letter to the PHP website under the provider notification section.</p> <p>A Medical Office Note to notify providers of the role, referral process, and contact information for the Behavioral Health Liaison is currently in the review process. Once approved this communication will be sent electronically to all participating providers.</p> <p>Updates to the Provider Manual for 2012 include role, and contact information for the Behavioral Health Liaison. The Provider Manual is currently in the review process.</p> <p>PHP is developing a presentation for the both the PCP and Specialist Workshops to educate on the role, referral process and contact information for the Behavioral Health Liaison.</p> <p>The plan will continue to look for additional opportunities to educate providers regarding the Behavioral Health Liaison.</p>		<p>Health Liaison. Annual PCP/specialist/staff workshops. Attendance records available.</p>	



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State Contract Requirements (Federal Regulation 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p><b><u>IPRO Comments:</u></b> Since the timeframe reviewed (July 1, 2010-June 30, 2011), PHP notified providers by letter of the availability, responsibilities and contact information of the Behavioral Health Liaison. Additional initiatives are in process, such as a Medical Office Note, updates to the Provider Manual and presentations to PCPs and specialists. No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
<p>Through initial implementation phases and continuing educational programs for Members and Providers, the Contractor shall ensure that each Provider understands which Behavioral Health Services are contained within the physical health plan and which Behavioral Health Services are covered by the Department through Medicaid fee for service.</p>		Full	<p>Addressed in P/P BH 14.0, Coverage of BH Services and P/P BH 3.0 Behavioral Health Liaison Responsibilities.</p> <p>Addressed through inclusion of the following language in the following formats: "The Behavioral Health Liaison: Provides education about services covered under PHP and Medicaid fee-for-service."</p> <p>Provider Letter 11/2/11. Posted on website 6/5/12. Medical Office Note 8/13/12. Updates to Provider Manual: 12.4. Behavioral Health and 12.4.1 Behavioral Health Liaison.</p>	



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State Contract Requirements (Federal Regulation 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Annual PCP/specialist/staff workshops.	
<p>If the Contractor denies a claim for Behavioral Health Services because it was not included with the Partnership Program, Contractor shall include information on the denial of the Claim for Behavioral Health Services on how the Member may be able to obtain the service requested from the Department through its fee for service program.</p>	<p><b><u>Recommendation for PHP</u></b>            The UM P/P should be revised to include information about the member's ability to obtain behavioral health services through the fee for service program if a behavioral health claim is denied and ensure that any denials related to behavioral health services include this information</p> <p><b><u>PHP Response:</u></b>            The policy will be updated to include the recommended language.</p> <p><b><u>IPRO Comments:</u></b>            No change in review determination.</p> <p><b>Minimal Compliance</b></p>	Substantial	<p>P/P UM 7.01, Prior (Prospective) Authorizations Procedures provided.</p> <p>Language does not address denials. Policy states if a request for prior authorization for EPSDT Special Services Behavioral Health related service or an inpatient Behavioral Health related service is received, member will be referred to DMS (does not specify FFS program).</p> <p>Language addressing denials for Behavioral Health Services was not found in other submitted documents for Care Coordination: Behavioral and Physical Health Care.</p> <p>P/P UM 7.01 was replaced by Policy Review Process on 12/5/12. Language does not address denials. Policy states if a request for prior authorization for EPSDT Special Services Behavioral Health related service or an inpatient Behavioral Health related service is received, member will be referred to Beacon Health Strategies. All other questions should be referred to the DMS Member Services line.</p> <p>Language addressing denials for Behavioral Health Services was not found in other submitted documents for QAPI</p>	<p><b>MCO Response:</b> Prior to January 2013, the Behavioral and Mental Health benefit, with the exception of the pharmacy benefit, was excluded from Passport Health Plan. The contract awarded by DMS to begin calendar year 2013 did include the comprehensive benefit. As a result many policy and procedures were updated. UM P/P 7.01 Prior (Prospective) Authorizations was updated to include if a request for prior authorizations for an EPSDT Special Services Behavioral Health related service, the member /provider would be referred to the Department of Medicaid Services fee for service program (prior to January 2013).</p> <p>In 2013, if Utilization Management receives a request for authorization for Behavioral Health Services the requestor will be transitioned to the Behavioral Health program administered in conjunction with Beacon Health Strategies. Requests are screened utilizing approved level of care by utilization review nurses. If the initial criteria are not met, then the request is referred to a Kentucky licensed Physician to either approve or deny the request based on a review of the clinical scenario which might include a peer to peer review. If a denial is the outcome, then this decision is communicated to the provider and member in writing. This communication outlines the appeal process including the ability to have a state fair hearing after all appeals have been</p>



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State Contract Requirements (Federal Regulation 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Utilization Management.  <b>Recommendation for PHP</b> Policies should be updated to include language regarding denials. PHP should ensure that Beacon Health Strategies policies address denials of claims.	exhausted through Passport Health Plan's Behavioral Health Program.  <b>IPRO Comments:</b> No change in review determination.
<b>9.2 Referral Between the Contractor and Behavioral Health Providers</b>				
Contractor will be required to provide a "Behavioral Health Liaison" function to facilitate access to Behavioral Health Services.		Full	Addressed by 2012 CCM Program Description. Section 11.  Addressed by BH 3.0, Behavioral Health Liaison Responsibilities.  Addressed by Behavioral Health Liaison Job Description.  BHL Notes Template contains the name of this staff person.	
The Contractor shall educate and assist PCPs regarding proper procedures for making referrals for behavioral health consultation and treatment. When a Primary Care Provider identifies a Member's need for Behavioral Health Services, the Provider may contact the Behavioral Health Liaison who will facilitate access to the appropriate Behavioral Health Services.	<b>Recommendation for PHP</b> The plan should ensure widespread education of providers regarding the availability and role of the BH liaison, as this information does not appear to be readily available in provider materials, the plan's website, or in clinical practice guidelines relevant to behavioral health referrals	Full	Addressed in P/P BH 15.0, Referral Guidelines for Behavioral Health Services. Addressed by Behavioral Health Liaison Referral Form.  Education regarding referral procedures to the Behavioral Health Liaison provided in the following formats:  Provider Letter 11/2/11. Posted on website 6/5/12.	



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State Contract Requirements (Federal Regulation 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p><b>PHP Response:</b> PHP notified all participating providers via letter regarding the availability, responsibilities, and how to contact the Behavioral Health Liaison in November 2011. Public Affairs to add letter to the website under the provider notification section.</p> <p>A Medical Office Note to notify providers of the role, referral process, and contact information for the Behavioral Health Liaison is currently in the review process. Once approved this communication will be sent electronically to all participating providers. Updates to the Provider Manual for 2012 include role, and contact information for the Behavioral Health Liaison. The Provider Manual is currently in the review process.</p> <p>PHP is developing a presentation for the both the PCP and Specialist Workshops to educate on the role, referral process and contact information for the Behavioral Health Liaison. The plan will continue to look for additional opportunities to educate providers regarding the Behavioral Health</p>		<p>Medical Office Note 8/13/12. Updates to Provider Manual: 12.4. Behavioral Health and 12.4.1 Behavioral Health Liaison. Annual PCP/specialist/staff workshops.</p> <p>It is also noted that the American Psychiatric Association (APA) Guidelines for Treatment of Patients with Major Depressive Disorder, MacArthur Foundation Depression Management Toolkit, and APA Practice Guideline for the Treatment of Patients with Panic Disorder available through PHP website at <a href="http://www.passporthealthplan.com/provider/resources/cpg/index.aspx">http://www.passporthealthplan.com/provider/resources/cpg/index.aspx</a>.</p>	



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	<p>Liaison.</p> <p>PHP adopted the American Psychiatric Association National Standard Guidelines for depression and anxiety. Links are provided for access to the guidelines on the Plan's website for providers to utilize as needed. PHP is unable to insert additional plan specific information due to the adoption of the national standard. Plan specific information must be disseminated via other methods.</p> <p>The plan will continue to look for additional opportunities to educate providers regarding the Behavioral Health Liaison.</p> <p><b><u>IPRO Comments:</u></b> No change in review determination.</p> <p><b>Substantial Compliance</b></p>			
<p>The Behavioral Health Liaison will involve the Member in the selection of the provider for Behavioral Health Services. The following are common indicators for referral to a behavioral health provider by a PCP:</p>	<p><b><u>Recommendation for PHP</u></b> The plan should consider identifying potential common indicators for behavioral health consultation in provider materials and clinical practice guidelines, and identify the availability of the BH liaison to facilitate consultation; see specific</p>	Substantial	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 Behavioral Health Liaison Responsibilities and annual PCP/specialist/staff workshops.</p>	<p><b>MCO Response:</b> The trigger list/common indicators will be added to the 2013 Case Management Program Description and care coordination policy CC 4.05 and the attachment A case management trigger list.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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State Contract Requirements (Federal Regulation 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>comments below</p> <p><b>PHP Response:</b> The common indicators are located in policy BH 15.0 – Referral Guidelines for Behavioral Health Services.</p> <p>PHP will investigate and develop a Behavioral Health referral form for the providers to utilize to make referrals to the Behavioral Health Liaison. PHP will make the form readily accessible to providers via the Plan's website.</p> <p>PHP adopted the American Psychiatric Association National Standard Guidelines for depression and anxiety. Links are provided for access to the guidelines on the Plan's website for providers to utilize as needed. PHP is unable to insert additional plan specific information due to the adoption of the national standard. Plan specific information must be disseminated via other methods.</p> <p>The 2012 Case Management Program Description will be updated with the Behavioral Health Liaison role and responsibilities and</p>		<p>Common indicators for referral are addressed by:</p> <p>P/P BH 15.0, Referral Guidelines for Behavioral Health Services, the Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p> <p>However, IPRO reviewer unable to locate referral form on the PHP website. As of 1/1/13, PHP contracted with Beacon Health Strategies to provide behavioral health services. But, as per interview, the BHL position remains active, so would expect to have been able to access referral form.</p> <p>Common indicators for referral are not addressed by:</p> <p>Complex Case Management (CCM) Program Description 2012. Section X1. Behavioral Health Liaison. Description received final approval by Quality Medical Management committee July 20, 2012. However, indications for referral to CCM do not include behavioral health indicators.</p> <p>The American Psychiatric Association (APA) Guidelines for Treatment of Patients with Major Depressive Disorder, MacArthur Foundation Depression</p>	



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	<p>presented to committee for recommendations and approval in July.</p> <p><b>IPRO Comments:</b> Review determination not changed; BH 15.0 not submitted with response.</p> <p><b>Substantial Compliance</b></p>		<p>Management Toolkit, and APA Practice Guideline for the Treatment of Patients with Panic Disorder available through PHP website at <a href="http://www.passporthealthplan.com/provider/resources/cpg/index.aspx">http://www.passporthealthplan.com/provider/resources/cpg/index.aspx</a>.</p> <p><b>Recommendation for PHP</b> PHP should update the Complex Case Management Program Description to include behavioral health indicators among indications for referral to CCM.</p>	
(a) Suicidal/homicidal ideation or behavior;	<p>CPG 15.13 for Depression identifies clinical indicators for behavioral health that include suicidal ideation and psychosis (2009) but does not identify the availability of the BH liaison</p> <p>The updated CPG from February 2011 refers to national guidelines but does not note the BH liaison</p>	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(b) At-risk of hospitalization due to behavioral health condition;	<p>The Macarthur Depression Management Toolkit for primary care found on the provider website under depression clinical practice guidelines includes</p>	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual</p>	



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	<p>recommendation for consultation with mental health professional for suicidal ideation, complex psychosocial needs or other active mental disorder</p> <p>There is evidence in the BH liaison tracking database of member referred for evaluation for hospital admission</p>		<p>PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(c) Children at imminent risk of out-of-home placement in a psychiatric hospital, PRTF or treatment foster care placement;	<p>This indicator is not identified in policy and there were no cases referable to this indicator</p> <p>The Medical Management Program Description identifies the BH liaison as working with special populations including children in out of home placement</p>	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(d) Trauma victims including possible abused or neglected Members;	<p>Child abuse and domestic violence are included in provider materials, but these and other forms of trauma are not evident in the context of referral for behavioral health services</p>	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p>	



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			<p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(e) Request by Member, parent or legal guardian;	<p>Member-self referral is included in triggers listed in the 2011 Medical Management program description</p> <p>There is evidence in the BH liaison tracking database and cases reviewed of member self-referral for BH services</p>	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(f) Clinical status that suggests the need for behavioral health services;	<p>CPG 15.13 identifies clinical indicators for behavioral health such as suicidal ideation and psychosis (2009); BH liaison is not identified</p>	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p>	



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			P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.	
(g) Identified psychosocial stressors;	Psychosocial issues and inadequate support are identified as potential triggers for complex case management in the Medical Management Program Description, but not specifically in provider documents for referrals	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(h) Treatment compliance complicated by behavioral characteristics;	This is identified as a potential trigger for complex case management in the Medical Management Program Description, but not specifically in provider documents for referrals except in the context of diabetes care	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual</p>	



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			PCP/specialist/staff workshops.	
(i) Behavioral, psychiatric and/or substance abuse factors influencing a medical condition;	These are identified as a potential triggers for complex case management in the Medical Management Program Description and also in the provider manual as reasons for case management, but not specifically for referrals	Full	Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:  P/P BH 3.0 and annual PCP/specialist/staff workshops.  This specific indicator for referral to a behavioral health provider by a PCP is addressed by:  P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.	
(j) Non-medical management of substance abuse;	This is not a specifically identified indication for referral in documents, but one of the BH liaison case reviews revealed referral to Alcoholics Anonymous	Full	Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:  P/P BH 3.0 and annual PCP/specialist/staff workshops.  This specific indicator for referral to a behavioral health provider by a PCP is addressed by:  P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.	
(k) Follow-up to medical detoxification;	This is not a specifically identified indication for referral in documents	Full	Involvement of the member in the selection of a provider for Behavioral	



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			<p>Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(l) The initial PCP contact or physical exam indicates a substance abuse or mental health problem;	The Macarthur Depression Management Toolkit for primary care found on the provider website under depression clinical practice guidelines includes recommendation for consultation with mental health professional for suicidal ideation, complex psychosocial needs or other active mental disorder; initial contact is not specifically mentioned	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual PCP/specialist/staff workshops.</p> <p>This specific indicator for referral to a behavioral health provider by a PCP is addressed by:</p> <p>P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.</p>	
(m) A prenatal visit indicates a substance abuse or mental health problem; or	A description of the Mommy and Me program in the Provider Manual notes that perinatal care managers will coordinate mental health/substance abuse services for	Full	<p>Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:</p> <p>P/P BH 3.0 and annual</p>	



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	members needing them, and providers are encouraged to access Mommy and Me for their patients, though not explicitly noting substance abuse/mental health problems as indications for referrals		PCP/specialist/staff workshops.  This specific indicator for referral to a behavioral health provider by a PCP is addressed by:  P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.	
(n) A pattern of inappropriate use of medical, surgical, trauma, urgent care or ER services that could be related to substance abuse or other behavioral health conditions		Full	Involvement of the member in the selection of a provider for Behavioral Health Services is addressed by:  P/P BH 3.0 and annual PCP/specialist/staff workshops.  This specific indicator for referral to a behavioral health provider by a PCP is addressed by:  P/P BH 15.0, Behavioral Health Liaison Referral Form and annual PCP/specialist/staff workshops.	
The Contractor's Behavioral Health Liaison will maintain information to help Members access non-covered outpatient substance abuse services following discharge from inpatient Medical Detoxification.	P/P BH 3.0 includes resources for identifying non-covered outpatient substance abuse services following discharge from inpatient Medical Detoxification	Full	Addressed by BH 3.0, Behavioral Health Liaison Responsibilities.	
<b>9.3 Coverage of Behavioral Health and Substance Abuse Services</b>				



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<p>Both the Department and the Contractor will provide Members with Behavioral Health Services and the responsibility for those services shall be billed as set forth below. Primary Care Providers are authorized to refer Member to a Behavioral Health Provider if indicated by the treatment plan. The Behavioral Health services provided by Contractor are included in the Capitation Payment payable to Contractor.</p> <p>Summary of behavioral services provided by Contractor and DMS:</p> <ul style="list-style-type: none"> <li>▪ Inpatient Acute Medical Detoxification and “scatter beds” in med/surg non-psychiatric beds for Members with a primary mental health diagnosis</li> <li>▪ Emergency Room Services (excluding psychiatric consults)</li> <li>▪ Physical health services to PRTF residents</li> <li>▪ Outpatient Mental Health Services provided through office visits by non-psychiatrist physicians and non-psychiatrist physicians employed by public health departments, primary care centers, and rural health centers</li> <li>▪ Psychotropic and other medications submitted on a pharmacy claim</li> <li>▪ All emergency transportation for Behavioral Health Service</li> <li>▪ All laboratory services</li> <li>▪ Supporting psychiatric services by HHAs to members not referred by a BH provider</li> <li>▪ BH service provided by Hospice</li> <li>▪ Social services provided by primary care centers</li> </ul> <p>TO BE PROVIDED BY DMS:</p>				



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<ul style="list-style-type: none"> <li>▪ Inpatient Mental Health treatment in a freestanding psychiatric hospital or psychiatric unit of a med-surg hospital.</li> <li>▪ Psychiatric consultation for hospital emergency room services or non-psychiatric admissions.</li> <li>▪ PRTF – Psychiatric Residential Treatment Facility</li> <li>▪ Outpatient Mental Health services provided by psychiatrists, community mental health center clinicians, such as such as psychiatrists and social workers, and other licensed or certified mental health practitioners.</li> <li>▪ Psychotropic and other medication prescribed by a psychiatrist or community mental health center psychiatrist, physician or ARNP and submitted on a medical claim</li> <li>▪ Therapeutic Rehabilitation Services</li> <li>▪ Targeted Case Management Services Adults</li> <li>▪ Targeted Case Management Services Children (except children served by Regional Interagency Councils)</li> <li>▪ Impact Plus Program Services</li> <li>▪ EPSDT Mental Health special services</li> <li>▪ EPSDT Substance Abuse special services</li> <li>▪ Non-emergency transportation to BH provider destinations</li> </ul>				
<p>The Behavioral Health Liaison shall interface with case managers from the identified Targeted Case Management agencies. The liaison shall work with case managers to identify what Covered Services, in conjunction with other identified social services are to be provided to the Member. The Department will provide the Contractor with a list of Medicaid-certified targeted case</p>				



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management agencies, with updates.				
<b>1.1 Definitions</b>				
<b>Behavioral Health Services:</b> means clinical, rehabilitative, and support services in inpatient and outpatient settings to treat a mental illness, emotional disability, or substance abuse disorder.				
<b>Care Coordination</b> 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 (a) provided by a care coordinator for each Member, (b) supervised by individuals with the equivalent training and experience of a person with an R.N. nursing degree and experience with disabled persons, or a certified social worker with a medical background, or a nurse practitioner. Care Coordination includes:				
(a) Development of the Care Plan;				
(b) Coordination of services, including the comprehensive organization of combined medical and social services across a continuum for the greatest benefit to the Member and the most efficient use of resources. This includes arranging for Covered Services and monitoring the provision of Covered Services;				
(c) Care evaluation, including tracking the outcome of services and the attainment of Care Plan objectives. Care or Service Plans may be adjusted accordingly; and				
(d) Service management, such as planning, coordination and evaluation certain Services, without formal Case				



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Management (e.g., arranging for transportation)				
<b>Care Management System</b> 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.				
<b>Care Plan</b> 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.				
<b>Case Management:</b> 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.				
<b>Medical Detoxification:</b> means management of symptoms during the acute withdrawal phase from a substance to which the individual has been addicted.				
<b>2.1 Administration/Staffing</b>				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the services provided by the Partnership Program. Responsibility for these functions or				



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staff positions may be combined or split among departments, people or Subcontractors.				
(h) A <b>Behavioral Health Liaison</b> who shall be responsible for coordination between the Contractor and Providers who render Behavioral Health Services to Members.				
(i) A <b>Case Management Coordinator</b> who shall be responsible for overseeing Case Management Services and continuity of care for all Members.				
<b>6.3 Primary Care Provider Responsibilities</b>				
Unless otherwise required hereunder, the PCP shall serve as the Member's initial and most important point of contact with the Contractor.		Full	Addressed in PHP Provider Manual available on the PHP website at <a href="http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf">http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf</a> .	
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:	<p><b><u>Recommendation to PHP</u></b> Evidence was provided of review of 606 medical records from 67 providers in 2011 (2010 data)</p> <p>As per QM 5.0, the plan monitors providers at least every three years for medical record documentation for the following: (see below)</p> <p><b><u>PHP Response:</u></b> None</p> <p>Substantial Compliance</p>	Substantial	<p>Addressed in PHP Provider Manual available on the PHP website at <a href="http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf">http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf</a>.</p> <p>Evidence of Medical Record Review and monitoring would not necessarily be available again per Policy QM 5.0 (conducted at least every 3 years).</p> <p>At the onsite review, the Director of Care Coordination and Quality Improvement indicated that the MCO would be able to submit most recent PCP Compliance with Medical Record Standards report. This</p>	<p><b>MCO Response:</b> In 2013, Passport initiated review of current medical record review practices including the medical record review tool, how results are communicated to the provider, the process for re-review, and the frequency of review. At this time, best practices' are being reviewed and changes are in draft from pending QI committee and Chief Medical Officer review and approval.</p> <p>As previously indicated, Passport will submit the most recent PCP Compliance with Medical Record Standards report for the EQRO to review.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>



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			<p>report was not provided.</p> <p><b>Recommendation for PHP</b> Determination of Substantial Compliance given to the section 'Primary Care Provider Responsibilities 'overall because monitoring interval as described in QM 5.0 (per prior IPRO comments) does not allow follow-up of prior review determinations and recommendations. Plan may want to reconsider monitoring interval.</p>	
(a) Maintaining continuity of the Member's health care;		Full	<p>Addressed in PHP Provider Manual available on the PHP website at <a href="http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf">http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf</a>.</p> <p>Evidence of Medical Record Review and monitoring would not necessarily be available again per Policy QM 5.0 (conducted at least every 3 years).</p>	
(b) Making referrals for specialty care and other Medically Necessary services, both in and out of plan, if such services are not available within the Contractor's Network;		Full	<p>Addressed in PHP Provider Manual available on the PHP website at <a href="http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf">http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf</a>.</p> <p>Evidence of Medical Record Review and monitoring would not necessarily be available again per Policy QM 5.0</p>	



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			(conducted at least every 3 years).	
(c) Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services		Full	Addressed in PHP Provider Manual available on the PHP website at <a href="http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf">http://www.passporthealthplan.com/pdf/provider/resources/manual/provider-manual.pdf</a> .  Evidence of Medical Record Review and monitoring would not necessarily be available again per P/P QM 5.0 (conducted at least every 3 years).	
(g) Arranging and referring members when clinically appropriate, to behavioral health providers.	Although age and disease appropriate services and referrals documentation is reviewed, standards do not explicitly refer to clinically appropriate behavioral health providers  It is notable that although overall compliance was 83.3% with medical record standards, relevant psychological and social conditions, mental/behavior health, and substance abuse history documentation fell below 80% for the second year in a row  <b><u>Recommendation for PHP</u></b> The plan should focus on ensuring appropriate assessment of	Full	Addressed by PHP Provider Manual available on the PHP website. The Section 'Role of the Primary Care Provider' explicitly refers to Behavioral Health Providers. "	



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	behavioral health by providers and referral to behavioral health providers as indicated  <b>PHP Response:</b> None  <b>Minimal Compliance</b>			
<b>7.1 Member Handbook</b>				
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:				
(j) Procedures for obtaining Medicaid Covered Services provided under Medicaid fee for service (e.g., applicable Behavioral Health Services and long-term care);				
(u) Information on the availability of, and procedures for obtaining mental health/substance abuse health services. The Contractor must work with Behavioral Health Services providers to coordinate Member access and availability for Behavioral Health Services;				
<b>8.2 Care Coordination/ Management Services</b>				
<b>Care Coordination</b> – The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for Members. Care coordination is a process to assure that the physical and behavioral health needs of the Medicaid population are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				



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The Contractor shall use the following primary elements for care coordination:				
(c) provide a designated person to be primarily responsible for coordinating the health services furnished to a specific Member and to serve as primary contact for the Member;				
(g) facilitate appropriate coordination between physical and behavioral health services and non-covered services;				
<b>8.4 EPSDT Early and Periodic Screening, Diagnosis and Treatment</b>				
(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. Coordination procedures shall also 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.				



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**Continuity & Coordination of Care: Behavioral and Physical Health Care**

**Scoring Grid:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	26	3	0	0
Total Points	78	6	0	0

**Overall Compliance Determination:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	<b>3.0</b>	<b>2.0 – 2.99</b>	<b>1.0 – 1.99</b>	<b>0 – 0.99</b>
Points Average		<b>84/29=2.90</b>		

**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



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**Continuity & Coordination of Care: Behavioral and Physical Health Care  
Suggested Evidence**

**Documents**

Policies/Procedures for coordination of behavioral and physical health services  
Position Description for Behavioral Health Liaison  
Evidence of provider education regarding availability and services of BH liaison  
Provider criteria/indicators for referrals to BH provider

**Reports**

MCO provider compliance monitoring results

**File Review**

File Review of a random sample of members who have received behavioral health liaison/case management services during the review period



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■ = Not Subject to Review

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<b>7.1.4 Member Rights and Responsibilities</b>				
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.				
A copy of the Contractor's policies and procedures shall be provided to all of the Contractor's Network providers and any outside 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.				
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;				
(b) A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;				
(c) Consent for or refusal of treatment and active participation in decision choices;				
(d) To ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;				



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(e) Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a hearing from the Contractor and/or the Department;				
(f) Timely access to care that does not have any communication or physical access barriers;				
(g) To prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;				
(h) To have access to Medical Records in accordance with applicable federal and state laws; and				
(i) Timely referral and access to medically indicated specialty care.				
(j) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.				
The Contractor shall also have policies addressing the responsibility of each Member to:				
(a) Become informed about Member rights:				
(b) Abide by the Contractor's and Department's policies and procedures;				
(c) Become informed about service and treatment options;				
(d) Actively participate in personal health and care decisions, practice healthy life styles;				
(e) Report suspected Fraud and Abuse; and				
(f) Keep appointments or call to cancel.				



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<b>7.1.1 Member Handbook</b>				
The Contractor shall publish a Member Handbook and make the handbook available to Members within two weeks of enrollment notification. The Contractor shall review the handbook at least annually and shall communicate any changes to all members in written form. Revision dates shall be added to the Member Handbook so that it is evident which is the most current version. All changes must be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	<p><b>Recommendation for PHP</b> P/P MS 3.0 Mailing of New Member Information should be updated to reflect the correct timeframe of within 2 weeks</p> <p><b>PHP Response:</b> Policy MS 3.0, Mailing of New Member Information, has been updated with correct timeframe of two weeks. The policy is attached for your review.</p> <p><b>IPRO Comments:</b> PHP has updated Policy MS 3.0 to state mailing will occur within 2 weeks. No change in review determination.</p> <p><b>Substantial Compliance</b></p>	Substantial	<p>Requirements addressed in P/Ps MS3.0, PA12.1 and PA9.0, with the exception of revision dates.</p> <p>A provision that revision dates be added to the Member Handbook was not found. A revision date on Handbook version 6 was not found. Note: The submitted file is entitled Member Handbook 2013.</p> <p><b>Recommendation for PHP</b> Policies should be updated to address inclusion of revision dates.</p>	<p><b>MCO Response:</b> Passport Health Plan accepts the recommendation. Previously, Passport Health Plan followed existing policy PA 27.0 (Oversight of Revision Date in Member Handbook) to ensure the revision date was included in each version of the Member Handbook. However, with the implementation of a document review and approval process by DMS, which assigns an approval code following DMS review, the revision date was removed and the approval code used instead.</p> <p>Passport will update policy PA 27.0 to require that both the revision date (i.e., December 2012) and the DMS approval code be included in each version of the Member Handbook and each insert. This is in progress and will be incorporated in the next revision of the Member Handbook in the Fall, 2013.</p> <p><b>IPRO Comments:</b> No change in review determination.</p>
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	<p>PHP utilizes Health Literacy Advisor to ensure 6<sup>th</sup> grade reading level for all member related reading materials including Braille, large type and audio</p> <p>Requirement-specific findings are noted below</p> <p><b>Substantial Compliance</b></p>	Full	Requirement-specific findings are noted below.	
(a) The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and		Full	The Member Handbook directs members to the PHP website and provides	



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service site addresses of PCPs available for Primary Care Providers in the network listing;			instructions to print or perform a customized search of the directory. If the member lacks access to a computer, he/she is directed to the Member Services telephone number.	
(b) The procedures for selecting an individual physician and scheduling an initial health appointment;		Full	The required information is included in the Member Handbook.	
(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 toll-free, 24 –hour hotline;		Full	The required information is included in the Member Handbook.  Numbers for the 24/7 Nurse Advice Line and Behavioral Health Hotline are given.	
(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;		Substantial	Covered services, limitations or exclusions are addressed in the Member Handbook.  A provision stating that the Contractor will be liable only for those services authorized by the Contractor was not found.  <b><u>Recommendation for PHP</u></b> The Member Handbook should be updated to include the required language regarding liability.	<b>MCO Response:</b> Passport Health Plan agrees with this finding. Language regarding plan liability will be added to the next version of the Member Handbook in the fall of 2013.  <b>IPRO Comments:</b> No change in review determination.
(e) Member rights and responsibilities including reporting suspected fraud and abuse;		Full	The required information is included in the Member Handbook.	
(f) Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use emergency medical services available or to activate emergency medical services by dialing 911;		Full	The required information is included in the Member Handbook.	



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(g) Procedures for obtaining transportation for both emergency and non-emergency situations;		Full	The required information is included in the Member Handbook and Insert 'Transportation.'	
(h) Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;		Full	The required information is included in the Member Handbook.	
(i) Procedures for arranging EPSDT for persons under the age of 21years;		Full	The required information is included in the Member Handbook and Insert 'EPSDT Program.'	
(j) Procedures for obtaining Medicaid Covered Services provided under Medicaid Fee-for-Service (e.g., applicable Behavioral Health Services and long term care)		Full	Long Term Care benefits and Behavioral Health Services are addressed in the Member Handbook.	
(k) Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;		Full	The required information is included in the Member Handbook.	
(l) Procedures for Dual Eligible Members to access services;		Full	The required information is included in the Member Handbook.	
(m) A list of direct access services that may be accessed without the authorization of a PCP;		Full	The required information is included in the Member Handbook.	
(n) Information about procedures for selecting a PCP or requesting a change of PCP and specialist; reasons for which a request may be denied; reasons a Provider may request a change;		Full	The required information is included in the Member Handbook.	
(o) Information about how to access care before a PCP is assigned or chosen;	<b>Recommendation for PHP</b> The Member Handbook should include information for new members about how to access care before a PCP is assigned or chosen	Substantial	Information on how to access care before a PCP is assigned or chosen was not found in the Member Handbook, or in the submitted Newsletters (2 <sup>nd</sup> Issue August 2012 or 3 <sup>rd</sup> Issue October 2012).	<b>MCO Response:</b> Passport Health Plan agrees with this finding. We will include this information in our Member Handbook in the fall revision of 2013, as well as annually in our member newsletter.



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	<p><b>PHP Response:</b> PHP has provided a copy of the 3<sup>rd</sup> Edition member newsletter, which contains information regarding how to obtain care prior to selecting a PCP or having a PCP assigned. This information can be found in the newsletter on Pg. 5.</p> <p>In addition, the Member Handbook will be updated and submitted to DMS in 3<sup>rd</sup> quarter 2012.</p> <p><b>IPRO Comments:</b> IPRO reviewed the 3<sup>rd</sup> Edition Member Newsletter. PHP will update the Member Handbook for submission to DMS. No change in review determination.</p> <p><b>Substantial Compliance</b></p>		<p>P.5 of the Member Handbook states "Your Passport ID card will be mailed to you after you call Member Services and choose a primary care physician."</p> <p>P.7 of the Member Handbook states "When you first become a Passport member, you will be assigned to a PCP. The name of your PCP will be listed on your ID card."</p> <p>P.11 lists Direct Access Services, available without seeing a PCP.</p> <p><b>Recommendation for PHP</b> Update Member Handbook to include procedure to access care before a PCP is assigned or chosen. Resolve discrepancies between information on pages 5 and 7.</p>	<b>IPRO Comments:</b> No change in review determination.
(p) Information about how to obtain second opinions related to surgical procedures, complex and/or chronic conditions;		Full	The required information is included in the Member Handbook.	
(q) Procedures for moving out of the Partnership Region as well as prompt notification to DCBS of relocation;		Full	Direction to notify DCBS of any major life change (including an address change) is included in the Member Handbook.	
(r) Procedures for obtaining Covered Services out of the Partnership Region;		Full	The required information is included in the Member Handbook.	
(s) Procedures for filing a Grievance or Appeal. This must		Full	The required information is included in the	



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include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;			Member Handbook.	
(t) Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;		Full	The required information is included in the Member Handbook.	
(u) Information on the availability of, and procedures for obtaining mental health/substance abuse health services. The Contractor must work with Behavioral Health Services providers to coordinate Member access and availability for Behavioral Health Services.		Full	The required information is included in the Member Handbook.	
(v) Information on the availability of health education services; and		Full	The required information is included in the Member Handbook.	
(w) Information deemed mandatory by the Department.		Full	The required information is included in the Member Handbook.	
(x) The availability of case management and disease management provided by the Contractor.		Full	The required information is included in the Member Handbook.	
<b>7.1.3 Member Information Materials</b> INTENTIONALLY OMITTED – reviewed under Member Education and Outreach				
<b>7.1.7. Second Opinions</b>				
<b>8.6 Second Opinions</b>				
The Contractor shall allow for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Partnership Program or arrange for the Member to obtain one outside of the network at no cost to the Member if unavailable in the Contractor's Network, at the				



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Member's request.				
<b>7.1 Member Services Functions</b>				
The Contractor shall have a Member Services function which is staffed Monday through Friday during regular business hours. Staff shall be available to speak face-to-face or by telephone with Members at any time during business hours.				
The Contractor shall have a toll-free 24-hour, seven days-per-week Member Services telephone number and a telecommunication device for the deaf to assist members in obtaining and appropriately using Emergency Care or Urgent Care.				
Provide a back-up telephone system that will operate, in the event of line trouble or other problems, so that access to the call center by telephone is not disrupted.				
The Contractor shall maintain a Member Services staff ratio in proportion to the Contractor's enrollment or projected enrollment.				
Appropriate foreign language interpreters shall be available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education.				
<b>...(This section intentionally omitted. Addressed in Member Education and Outreach)...</b>				
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				



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provided.				
The Contractor's Member Services function shall also be responsible for:				
(a) Representing the interests of members before the boards of the Contractor and the Department;				
(b) Reviewing and commenting on policies of the Contractor and the Department;				
(c) Ensuring that Members are informed of their rights and responsibilities;				
(d) Monitoring the selection and assignment process of PCPs;				
(e) Identifying, investigation, and resolving Member Grievances about health care services;				
(f) Assisting Members with filing formal Appeals regarding plan determinations.				
(g) Providing each Member with an identification card that identifies the Member as a participant in the Partnership Program, unless otherwise approved by the Department;				
(h) Explaining rights and responsibilities to Members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse; (i) Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;				



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(j) Within two weeks of enrollment notification, and whenever requested by member, guardian or authorized representative, provide a Member Handbook and information on how to access services; (alternate notification methods must be available for persons who have reading difficulties or visual impairments);				
(k) Explaining or answering any questions regarding the Member Handbook;				
(l) Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist Members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. Notifying Members within thirty (30) days prior to the effective date of voluntary termination (or if the Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as the 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;				
(m) Facilitating direct access to specialty physicians in the circumstances of:				
1. Members with long-term, complex conditions				
2. Aged, blind, deaf, or disabled persons, and				
3. Individuals who have been identified as having special				



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healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through standing referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.				
(n) Arranging for and assisting with scheduling EPSDT services in conformance with federal law governing Early and Periodic Screening, Diagnosis and Treatment for persons under the age of twenty-one (21) years;				
(o) Making referrals for relevant non-Program provider services such as the Women, Infants, and Children (WIC) supplemental nutrition program and Protection and Permanency;				
(p) Facilitating direct access to primary care vision services; primary dental and oral surgery services and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation, and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Attachment V of this Contract;				
(q) Facilitating access to pharmaceutical services;				
(r) Facilitating access to the services of public health departments, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriners' Hospital for Children;				
(s) Assisting Members in making appointments with				



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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 must document and refer such problems to the designated Contractor liaison and Quality and Member Advisory Committee for resolution;				
(t) Assisting Members in obtaining transportation for both emergency and appropriate non-emergency situations;				
(u) Assisting Dual Eligible Members to access necessary services;				
(v) 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;				
(w) Facilitating access to Member Health Education Programs;				
(x) Assisting Members in completing the Health Risk Assessment (HRA) form 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.				
(y) Providing Members with information related to support services offered outside the Partnership Program such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse..				



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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 and the Quality and Member Access Advisory Committee.				
<b>(COST SHARING)</b> <b>8.1.3 Billing a Member</b>				
The Contractor and its Providers shall not bill a Member for Medically Necessary Covered Services covered under this contract and provided during the Member's Enrollment...This provision shall remain in effect even if the Contractor becomes insolvent.				
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of service does not relieve the Contractor, Providers or 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.				
<b>7.1.5 Choice of Providers</b>				
Dual Eligible Members, where Medicare is the primary insurer, and Members who are presumptively eligible or foster children, are not required to have a PCP. All other				



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Members in the Partnership must choose or have the Plan select a PCP for their medical home.				
The Contractor shall determine a method for assignment of Primary Care Providers which is consistent with the any willing provider statute, KRS 304.17A-270.				
There are two different processes for choosing a PCP for those Members who are eligible for a PCP relationship: (a) one process for Members who have SSI coverage but are not Dual Eligible Members, and (b) one process for all other Members (see <b>Contract section 7.1.5 for further detail</b> ).				
<b>7.1.6 PCP Changes</b>				
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 ordered as part of the resolution to an Appeal.				
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.				
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...Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in				



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(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 Partnership Region.				
The Member shall also have the right to terminate 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.				
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; inability to meet the medical needs of the Member; or upon determination by the Contractor.				
PCPs shall not have the right to request a Member's Disenrollment from their practice in the following situations: 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 the grounds of race, color, national origin, handicap, age or gender. The Contractor shall approve all transfers.				
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to Appeal such a transfer in the formal Appeals process. The Provider shall				



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make the change request in writing. Member may request PCP change in writing, face to face or via telephone.				
<b>8.1 Medicaid Covered Services</b>				
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Attachment V to all members in accordance with the standards set forth in this Contract, and according to the Department's policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Recipients at the time of enrollment. The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor must ensure continuity of care for new members receiving health care under fee for service prior to enrollment in the Plan. Attachment V shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not meant, 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. If the Contractor questions whether a service is covered or not covered, the Department shall reserve the right to make the final determination based on Kentucky administrative regulations in effect at the time the Contract is negotiated in accordance with KRS Chapter 45A.				
<b>(Note: text regarding added services intentionally</b>				



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omitted)				
If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, 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. Failure to follow applicable regulations and properly complete and maintain specific forms as required shall result in the application of sanctions as provided in this Contract. The preceding clause is not to be construed as requiring the Contractor to provide coverage for counseling or referral service if it objects to the service on moral or religious grounds and makes available information on its policies and to Members within ninety (90) days after the date the organization adopts a change in policy regarding such a counseling or referral service.				
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.				
If the Contractor is unable to provide necessary medical services covered under this Contract, it shall timely and adequately cover these services out of network for the Member for as long as the Contractor is unable to provide them. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will use its best efforts to ensure that cost to the Member is no greater than it would be if the services				



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were provided within the Contractor's Network.				
<b>ATTACHMENT V of the Contract MEMBER COVERED SERVICES AND SUMMARY OF BENEFITS PLAN</b>				
<b>A. General Requirements and Limitations</b>				
The Contractor shall provide, or arrange for the provision of, health services, including Emergency Medical Services, to the extent services are covered for Recipients under the then current Kentucky State Medicaid Plan, as designated by the department in administrative regulations adopted in accordance with KRS Chapter 13A and as required by federal and state regulations, guidelines, transmittals, and procedures... ...Kentucky's administrative regulations are also accessible via the Internet at <a href="http://www.ky.gov">http://www.ky.gov</a> ... ...Kentucky Medicaid covers only Medically Necessary services. These services are considered by the Department to be those which are reasonable and necessary to establish a diagnosis and provide preventive, palliative, curative or restorative treatment for physical or mental conditions in accordance with the standards of health care generally accepted at the time services are provided, including but not limited to services for children in accordance with 42 USC 1396d(4). Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The amount, duration, or scope of coverage must not be arbitrarily denied or reduced solely because of the diagnosis, scope or illness, or condition...				
<b>FOR FURTHER INFORMATION, REFER TO ATTACHMENT V 907 KAR</b>				



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<b>8.9 Referral for Non-covered Contractor Services</b>				
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.				



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**Scoring Grid:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	23	3	0	0
Total Points	69	6	0	0

**Overall Compliance Determination:**

<b>Compliance Level</b>	<b>Full</b>	<b>Substantial</b>	<b>Minimal</b>	<b>Non-Compliance</b>
Points Range	<b>3.0</b>	<b>2.0 – 2.99</b>	<b>1.0 – 1.99</b>	<b>0 – 0.99</b>
Points Average		<b>75/26=2.88</b>		

**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



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■ = Not Subject to Review

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**Documents**

Policies/Procedures for:

- member rights and responsibilities
- distribution of Member Handbook
- selection/assignment of PCP
- PCP changes
- referral for non-covered services provided by FFS Medicaid providers
- Second Opinions
- Member Services Department including member services functions
- Cost Sharing

Member Handbook including any separate inserts or materials

Benefit Summary (covered/non-covered services)

Sample Member newsletters and other informational materials

Sample Provider newsletters and other informational materials

Provider Manual or the 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 ID card and Member Handbook within two weeks of enrollment

Evidence that Member Handbook is reviewed/revised annually

Evidence that changes in the Member Handbook are submitted to and approved by DMS

Evidence that changes in the Member Handbook are sent to members in written format

**Reports**

Census information on common ethnicities and languages other than English spoken by ten percent (10%) or more of the enrolled population in a county



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Annual Member Services Report to management, DMS and QMAC with recommendation(s) regarding improvements in Member Services functions that could improve quality of care or the method of delivery