



**KY EQRO ANNUAL REVIEW  
March 2014**

**Period of Review: January 1, 2013 – December 31, 2013  
MCO: CoventryCares of Kentucky (CCKY)**

**Final Report 7/31/2014**

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

State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<b>19.1 QAPI Program</b>				
<p>The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.</p>	<p>Full - Coventry Cares has implemented a QAPI program as outlined in the QI Program Strategy 2012, QI Work Plan, UM Program Description, EQIC Description, Subcommittee and Org Chart, and policies and procedures. Monitoring, evaluating and implementing improvement interventions are also presented in the Annual QI Evaluation Report, which for the last reporting period (2011) was somewhat limited due to recent plan start-up. There has been a great deal of progress since an onsite meeting in October 2012 in implementing several initiatives and improving the quality structure. Quarterly reports, PIP report and committee minutes reveal assessment, monitoring, evaluation and improvement efforts are ongoing.</p>	<p>Full</p>	<p>CCKY has implemented a QAPI program as outlined in the QI Program Description, QI Work Plan and UM Program Description. These include: program goals and objectives, EQIC Description, components of improvement activities, governing body and committee structures/roles, available resources, and process of program evaluation.</p> <p>The 2012 Annual Evaluation provides a comprehensive report on the plan's approach to ensuring quality of care. EQIC committee and reporting subcommittees meet quarterly. Minute summaries (report 21) and PIP reports reveal that assessment; monitoring, evaluation and improvement processes are ongoing.</p> <p>On interview, CCKY described its 2013 goals as:</p> <ul style="list-style-type: none"> <li>▪ Improving access and availability</li> <li>▪ Decreasing inappropriate ED utilization</li> <li>▪ Increasing the number of women who complete postpartum visits</li> <li>▪ Improving care for major</li> </ul>	



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			<ul style="list-style-type: none"> <li>▪ depression and ADHD (PIPs)</li> <li>▪ Decreasing post op infection rates</li> <li>▪ Addressing substance abuse in pregnancy</li> <li>▪ Improving continuity of care/decreasing preventable inpatient readmissions (PIP)</li> <li>▪ Increasing rates of EPSDT services</li> <li>▪ Developing disease management programs for prevalent chronic diseases.</li> </ul>	
<p>The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.</p>	<p>Substantial - Coventry Cares Kentucky's 2012 QI Program Strategy describes the structure and processes that the plan has implemented to monitor, evaluate and improve care and services. The strategy identifies the roles of staff and the committee structure in place to support quality initiatives. The strategy includes monitoring of key indicators such as adverse events and HEDIS measures. The plan also has policies outlining the process for monitoring of grievances and appeals, including quality of care concerns, and access.</p> <p>The QI Program Strategy indicates that the plan will annually review the assessment, analysis and implementation of interventions for member and provider grievances and appeals, cultural factors that impact members, behavioral health issues, utilization and clinical data, access and availability and network adequacy. The Work Plan outlines specific processes underway for evaluating health care outcomes, including HEDIS measures and Healthy Kentuckian measures. The plan has been monitoring</p>	<p>Full</p>	<p>CCKY Kentucky's 2013 UM Program Description and QI Program Description describe the structure and processes that CCKY has implemented to monitor, evaluate and improve care and services.</p> <p>The UM Program Description identifies the roles of staff and the committee structure in place to support quality initiatives.</p> <p>The overview of the EQIC committee and QMUM subcommittee includes monitoring and oversight of key indicators such as adverse events, HEDIS measures, and adoption of clinical guidelines.</p>	



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	<p>monthly HEDIS administrative rates as per onsite staff and quarterly reports.</p> <p>Delegation oversight is included in the QI Program Strategy. The processes for evaluating access with regard to appointment availability are described in P/P PR-006. The plan monitors the availability of provider appointments with secret shopper methodology; PCP calls have begun and specialist calls are scheduled to follow next quarter as per plan onsite staff. Per P/P PR-006, a percentage of PCPs are surveyed quarterly via secret shopper calls, which address urgent care, routine care, preventive care and specialty care. During the onsite meeting in October, the staff indicated that there was some concern about after-hours access and provider availability in rural areas, and that the plan was also monitoring and evaluating ED utilization and Geo Access reports. During the compliance review, onsite staff noted that mapping of urgent care centers was also undertaken.</p> <p>The Utilization Management Program Description describes processes to monitor and report sentinel events and quality of care concerns, ED Utilization and over and under utilization, including pharmacy, hospital readmission and lead screening. The Work Plan indicates tracking of adverse events and member and provider complaints and grievances (category, type intervention and turnaround times). The Summary of Quality Improvement activities report (report 16) notes the top complaints categories.</p> <p>The UM Program Description also notes that Health Services staff identifies members in need of EPSDT services. EPSDT screening</p>		<p>The 2012 Annual Evaluation and the 2013 QI Program Description provide detailed descriptions of the methods used to monitor, evaluate and improve care and services.</p> <p>The QI Program Description identifies the roles of staff and the committee structure in place to support quality initiatives.</p> <p>Results of activities including conducting population analysis, improving access to care, assuring continuity of care, evaluating and disseminating clinical guidelines, monitoring grievances and appeals. Conduct of performance improvement projects is described in the 2012 Annual Evaluation.</p> <p>The Work Plan indicates that CCKY conducts annual reviews of the assessment, analysis and implementation of interventions for member and provider grievances and appeals, cultural factors that impact members, behavioral health issues, utilization and clinical data, access and availability and network adequacy.</p>	



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	<p>rates are being monitored by the plan as documented in quarterly reports, though not noted in the QI Work Plan.</p> <p>The QI Work Plan includes analysis of the health plan population's demographic profile annually, as well as an annual cultural assessment, to prioritize QI activities as recommended by the Executive Quality Improvement Committee (EQIC). This includes high volume diagnoses.</p> <p>The QI Work Plan indicates that CAHPS surveys (adult, child and children with chronic conditions) will be conducted in 2013; annual disease management, case management and customer surveys will also be conducted.</p> <p>Health Risk Assessment (HRA) completion rates are monitored by the plan.</p> <p>Member grievances and Quality of Care concerns have been noted by the plan and in review of files to have some opportunity for improvement with regard to categorization to ensure that all quality of care concerns are appropriately investigated by health care professionals and tracked.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should ensure appropriate identification and categorization of all member quality of care concerns, and the plan should further investigate trends of specific categories of quality of care concerns and adverse events when there are sufficient data to analyze by type (e.g. hospital acquired infections).</p>		<p>Also, the Work Plan outlines specific processes underway for evaluating health care outcomes, including HEDIS measures.</p> <p>According to the 2012 Annual Evaluation, delegation oversight processes are in place to monitor and evaluate subcontractors. Monthly meetings cover operational concerns. Quarterly oversight meetings are held to review performance, delivery of services, and relevant updates to policies and procedures. All delegates undergo a formal review annually.</p> <p>P/P PR-006 describes the processes for evaluating appointment availability. CCKY monitors the availability of appointments using a secret shopper methodology. Per P/P PR-006, a percentage of PCPs are surveyed annually using secret shopper calls to assess appointment availability for urgent care, routine care, preventive care and specialty care.</p> <p>The Utilization Management Program Description describes processes to monitor and report a variety of quality</p>	



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	<p><b>MCO Response:</b> None</p>		<p>measures including medical necessity, timely care, consistency in authorization of care, care based on clinical standards, and appropriate cost of care.</p> <p>The Work Plan reflects tracking of adverse events and member and provider complaints and grievances (category, type intervention and turnaround times).</p> <p>Health Risk Assessment (HRA) completion rates are monitored by the plan.</p> <p>The Annual Evaluation describes several processes to improve care provided to members with results. CCKY conducted two PIPs, developed care management programs for members with chronic and/or behavioral health conditions, implemented interventions to improve rates of postpartum care compliance, and to ensure PCP follow-up after inpatient discharge.</p> <p>CCKY conducted its first CAHPS survey (report 94) to assess member</p>	



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			<p>satisfaction. The results revealed opportunities to improve shared decision making, communication between member and providers, overall rating for adult care, overall rating for the plan, and customer service. The plan's provider newsletter provided information on how to improve shared decision making. This topic was also covered in the Quality Member Access Committee (QMAC) meeting minutes.</p> <p>In 2013, IPRO recommended that CCKY should ensure appropriate identification and categorization of all member quality of care concerns, investigate trends in quality of care concerns and adverse events when there are sufficient data to analyze by type (e.g., hospital acquired infections).</p> <p>The grievance file review reflected a substantial improvement in referrals for potential quality of care concerns (see Grievances tool for details). CCKY conducted a focused study on post-op wound infections. The study revealed that the infections were</p>	



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			<p>primarily due to member non-compliance. CCKY initiated a discharge planning program and home health follow-up to address the finding.</p> <p>The prior review revealed that CCKY staff was concerned about after-hours access and provider availability in rural areas and was also monitoring and evaluating ED utilization and Geo Access reports. In response, CCKY has worked with hospitals to develop urgent care services and recruiting additional urgent care centers: Kroger, CVS Minute Clinic, and some Wal-Mart stores. CCKY is conducting a PIP focused on reducing unnecessary ED utilization.</p> <p>In the prior review, it was noted that although the quarterly reports indicate that CCKY monitors EPSDT screening rates this was not included in the QI Work Plan. On interview, CCKY stated that there is a dedicated work plan for EPSDT initiatives. The EPSDT work plan was reviewed and includes monitoring and follow-up of EPSDT screening rates.</p>	



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			<p><b>Recommendation for CCKY</b> CCKY should consider referencing the EPSDT work plan in the QI Work Plan or include as an attachment to the QI Work Plan.</p>	
<p>The Contractor's QI structures and processes shall be planned, systematic and clearly defined.</p>	<p>Full - The plan has implemented a QAPI program as outlined in the QI Program Strategy, the UM Program Description and various policies and procedures as outlined above. The identified purpose of the QAPI program is to monitor and improve outcomes of care, services, safety, and satisfaction and to promote culturally competent, cost effective delivery of services. The QI Work Plan outlines planned QI activities. The MCO quarterly reports include quality activity updates in an updated QI Work Plan (Report 17, Quality Assessment and Performance Improvement Work Plan). This document identifies quarterly status and activities in greater detail than the QI Work Plan.</p> <p>The QI Work Plan submitted for the review identifies targeted areas of QI activities addressed by the plan, and demonstrates planned monitoring of customer service call answering metrics, pharmacy and UM call answering metrics, UM decision accuracy, Geo Access and appointment availability, member satisfaction, complaints and grievances and appeals turnaround times. Planning for HEDIS reporting in 2013 is included in the Work Plan, and Healthy Kentuckian measures are included as categories, although no planned activities are documented. Delegation oversight, provider satisfaction, Performance Improvement Projects (PIPs) and quarterly reporting are also included as categories in the Work Plan. Many activities have been implemented since the October 2012 onsite meeting.</p>	<p>Full</p>	<p>The plan has implemented a QAPI program as outlined in the QI Program Description, the UM Program Description, and 2012 Annual Evaluation as described above. The stated purpose of the QAPI program is to monitor and improve outcomes of care, services, safety, and satisfaction and to promote culturally competent, cost effective delivery of services. The QI Work Plan outlines planned QI activities.</p> <p>In 2013, IPRO recommended that CCKY consider describing the status and activities completed in the QI Work Plan.</p> <p>The QI Work Plan has been updated to include a comments column where descriptive updates are provided. Additionally, the committee meeting minutes provide detailed information.</p>	



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	<p><b><u>Recommendation for Coventry Cares</u></b> The plan should consider including detailed quarterly status and activities in the QI Work Plan.</p>			
<p>The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.</p>	<p>Full - As the plan has not yet reported annual HEDIS or Healthy Kentuckian data, QI activities linked to evaluation findings are somewhat limited. The plan has not yet had access to an EQR annual evaluation, accreditation reviews or findings from annual HEDIS indicators and member surveys.</p> <p>The plan does provide evidence of internal surveillance and of metrics including customer service and other call metrics, HRA completion, complaints and grievances and adverse events, and EPSDT screens, as well as utilization metrics.</p> <p>One of the more commonly identified adverse events is documented to be hospital acquired infection, which could be further analyzed regarding root cause when more data are available.</p> <p>Quality of care issues per policy are tracked, analyzed and referred to appropriate committees (QM/UM, Peer Review and Credentialing), and meeting minutes include discussion of potential quality concerns.</p> <p>PIP proposal submissions had strong rationales that included analysis of the plan's utilization metrics showing high ED use and a medication possession ratio demonstrating suboptimal adherence to antidepressants.</p>	<p>Full</p>	<p>Preparations for NCQA accreditation survey are in process. This is reflected in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan. The on-site review will take place on 07/28/14 and 07/29/14 with a look-back period of 6 months (new plan).</p> <p>CCKY provided the HEDIS measure results. The QMUM meeting minutes discuss how lower performing measures will be addressed. A Provider newsletter (Vol 1 Issue 2) describes HEDIS improvement initiatives focusing on preventive health services/ screenings and chronic disease management. Documentation revealed that CCKY intends to target the following measures for improvement: lead screening (LSC), weight assessment and counseling (WCC), well care visits (15 months, 3 – 6 years), prenatal and postpartum care (PPC) and a variety of chronic care measures (e.g., CDC, CBP, among others).</p>	



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	<p>HRA completion rates were noted to be low, and the plan has implemented a work group to address this issue with their vendor as per onsite staff. This is an important initiative, since the HRA is an important component of plan activities, such as outreach to smokers for cessation assistance.</p> <p>EPSDT rates were noted to be low, and the plan has implemented an EPSDT toolkit, EPSDT training modules for providers, feedback regarding members missing screens and an EPSDT audit tool.</p> <p>The plan conducted a medical record audit that revealed BMI and Advance Directives to be areas with opportunity for improvement; this feedback was given to providers.</p> <p>The plan identified several interventions that would be undertaken in response to provider survey results.</p> <p>The plan has implemented an asthma program for providers.</p> <p>MCO quarterly reports indicate that an action plan will be implemented for Geo Access if needed. The plan indicated that a contract was initiated with a Federally Qualified Health Center (FQHC) to improve access, and other initiatives including increasing urgent care center access and surveying providers regarding accepting members out of panel.</p>		<p>The QI Program Description outlines the process for linking evaluation data from various sources to QI initiatives.</p> <p>The Work Plan includes the rationale for activity selection, which include accreditation, contract requirements, EQRO review, or delegation oversight.</p> <p>The 2012 Annual Evaluation identifies hospital acquired infections (HAI) as the most commonly occurring adverse event. HAIs are tracked and reports are reviewed monthly by Medical Director and QMUM reviews these events bi-annually. Corrective action is implemented.</p> <p>Quality of care issues per policy are tracked, analyzed and referred to appropriate committees (QM/UM, Peer Review), and meeting minutes include discussion of potential quality concerns.</p> <p>2014 PIP proposal focuses on reducing hospital readmissions. 2013 PIPs focus on identification and treatment of major depression and reduction of ED utilization. All PIP indicators</p>	



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			<p>demonstrate substantial opportunity for improvement.</p> <p>2013 was the first year that CCKY administered the CAHPS survey. The CAHPS survey report (report 94) identified the following as opportunities for improvement: shared decision making, overall rating for adult care, overall rating for plan, and provider communication with members. An internal workgroup discussed barriers and interventions were developed.</p> <p>The provider satisfaction survey had a 24% response rate and revealed the following opportunities for improvement: resolution of inquiries, claims/payment process, and prior authorizations process. Interventions were not discussed.</p> <p><b><u>Recommendation for CCKY</u></b> It was suggested that CCKY consider including HEDIS adolescent well care (AWC) and frequency of prenatal care (FOP) among the measures targeted for improvement since the majority of the MCO's membership is children and</p>	



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			women of child-bearing age.	
The QAPI program shall be developed in collaboration with input from Members.	Full - The updated QI Program Strategy updated 11/26/12 notes that member input will be solicited in various ways including through satisfaction surveys. The CAHPS survey is underway at the time of the review. The plan cites voiced concerns of members regarding barriers to care in the rationale for their Performance Improvement Project (PIP) regarding Emergency Department (ED) utilization. The QI Program Strategy identifies the Quality and Member Access Committee (QMAC) as a subcommittee of the Executive QI Committee, and the purpose of the committee is to obtain feedback from members on marketing materials, customer service, network access, benefit interpretation, and the health plan overall. While the first QMAC meeting in April 2012 was informational, minutes from subsequent meetings in September and December 2012 reflect these activities and input from members on the QAPI program. Discussions included an overview of QI and HEDIS measures, review of the Member Handbook and Provider Directory, and discussion of PIPs. Members provided input on the plan's website, and a question and answer period is documented.	Full	<p>2013 was the first year that CCKY administered the CAHPS survey. The CAHPS survey report (report 94) identified the following opportunities for improvement: shared decision making, overall rating for adult care, overall rating for health plan, and provider communication with members. An internal workgroup discussed barriers and interventions were developed.</p> <p>The QI Program Description and CCKY quarterly reports identify the Quality and Member Access Committee (QMAC) as a subcommittee of the Executive QI Committee. The purpose of the committee is to obtain feedback from members on marketing materials, customer service, network access, benefit interpretation, and the health plan overall. The meetings occur quarterly by region. Meeting minutes reflect conduct of the stated activities and input from members on the QAPI program. Discussions included an overview of QI Program Description and Work Plan, HEDIS measures, NCQA process, CAHPS survey, and review of</p>	



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			<p>the Member Handbook, Provider Directory, and formulary. Members expressed concerns over barriers to access to dental care. These concerns were brought to the EQIC committee as documented in EQIC meeting minutes.</p> <p>Upon interview, CCKY described the actions taken to evaluate and address the member concerns regarding dental access. Avesis, the dental vendor, conducted a GeoAccess evaluation which revealed that access was adequate and that member perception may be the root of the complaints. Avesis also undertook an initiative to link members to network orthodontists.</p>	
<p>The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.</p>	<p>Full - Minutes were provided for QMAC meetings from 4/25/12, 9/12/12 and 12/19/12. Minutes included topics discussed as noted above, including Performance Improvement Projects (PIPs) and member comments. Member-voiced concerns are noted in the rationale for the PIP proposal as noted above, and the plan is in the process of conducting CAHPS surveys. The plan tracks member concerns (complaints and grievances) as noted in the Work Plan, and member complaints and grievances receive acknowledgement/resolution letters.</p> <p>The plan included a customer service survey response in their</p>	<p>Full</p>	<p>QMAC minutes described the activities and discussion of the committee as stated previously. In addition to the member concerns about access to dental care, issues with medical appointment availability and availability of interpreters were expressed. CCKY staff at the QMAC meetings encouraged members to file grievances and use the 24 hour Nurse line when needed. Members can</p>	



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	<p>complaints files. The member had forwarded a complaint regarding medication coverage, and the plan responded to this member's input.</p> <p>As per the QI Program Strategy, members can access a copy of the QI Program Strategy through Customer Service.</p>		<p>access a copy of the QI Program Strategy through Customer Service and on the website.</p> <p>During the onsite review, CCKY described efforts to expand its provider network and monitoring of access to care in each region. CCKY also explained that the MCO uses a language line type service and has interpreters available to attend inpatient visits and assist members in the hospital. CCKY described an issue related to translation of Burmese, but it was a knowledge issue and was addressed. Members' primary language other than English is Spanish. The call center located in Houston is staffed with English/Spanish bilingual associates.</p>	
<p>The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.</p>	<p>NA - The plan is preparing for NCQA accreditation, and the QI Work Plan notes an anticipated NCQA accreditation as of 2014. The plan is involving all departments in preparation, and EQIC minutes reflect ongoing preparation for accreditation.</p>	<p>Not Applicable</p>	<p>CCKY is preparing for its initial NCQA accreditation survey and this is reflected in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan. Preparations have included mock audits. The accreditation survey is scheduled for 07/28/14 and 07/29/14.</p> <p>MHNet, the BH vendor, hold both</p>	



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			URAC and NCQA accreditation.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	NA - Not applicable; the plan has not yet begun the NCQA accreditation process.	Not Applicable	NCQA accreditation survey is pending.	
Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.	Full - The QAPI program description was outlined in the document QI Program Strategy 2012, dated 7/25/12 and updated 11/26/12; the strategy was submitted to DMS 7/30/12 as per the QI Work Plan and EQIC minutes.	Full	Work Plan indicates the QI Program Description was submitted in July 2013. May 22, 2013 EQIC meeting minutes indicate that the description was sent to DMS by the time of the EQIC meeting.	
As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to	Full - The QI Program Strategy indicates that members' behavioral health needs are provided for and behavioral health and physical health services are coordinated to improve identification and care for members with behavioral health needs. Behavioral health services are integrated into the plan and QAPI program, and behavioral health and physical health are coordinated at the plan level and individual case level. Administration and management of behavioral health services	Full	MHNet, an NCQA accredited Managed Behavioral Health Care Organization (MBHO) and CCKY subsidiary administers and manages behavioral health services (mental health and substance abuse). The QI Program Description indicates that behavioral health and physical health services are	



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Members.	<p>(mental health and substance abuse) is undertaken by MHNet, an NCQA accredited Managed Behavioral Health Care Organization (MBHO). MHNet is Coventry owned. Behavioral health quality improvement activities and utilization management are delegated to MHNet, but behavioral health and physical health actively work together on PIPs and other initiatives (e.g. substance abuse among pregnant women and behavioral health-physical health continuity of care). The plan and MHNet hold regular operational meetings to monitor performance as per quarterly reports.</p> <p>There is behavioral health representation on the Executive Quality Improvement Committee (EQIC) and Quality Management/Utilization Management (QM/UM Committee. EQIC and QM/UM minutes include discussion of behavioral health issues, such as adoption of behavioral health guidelines. MHNet behavioral health care advocates are co-located at the health plan to integrate treatment and case management activity, and they interact with physical health case managers to coordinate care and address comorbidities. The collocation also facilitates referrals between behavioral health and physical health.</p> <p>The QI Program Strategy notes that members are surveyed for mental health status in multiple existing quality programs. There are weekly Coventry Cares/MHNet team meetings and case management rounds, which also offer opportunity for nurses to interact with MHNet staff and Medicaid pharmacists as per the Annual Evaluation.</p>		<p>coordinated to improve identification of and care for members with behavioral health needs at both the plan and individual member level.</p> <p>Behavioral health services are integrated into the QAPI program. Behavioral health QI and UM activities are delegated to MHNet, but behavioral health and physical health staffs actively collaborate on PIPs and other initiatives (e.g. substance abuse among pregnant women and behavioral health-physical health continuity of care). CCKY and MHNet hold regular operational meetings to monitor performance.</p> <p>Behavioral health has representation on the Executive Quality Improvement Committee (EQIC) and Quality Management/Utilization Management (QM/UM) Committee. EQIC and QM/UM meeting minutes demonstrate discussion of behavioral health issues, such as adoption of behavioral health clinical guidelines.</p> <p>MHNet behavioral health care advocates are co-located at the health</p>	



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	<p>The plan monitors behavioral health utilization indicators as per quarterly reports, and is working to clarify other indicators. The plan conducted behavioral health member surveys in 2012.</p>		<p>plan to integrate treatment and case management activity, and to coordinate with physical health case managers. The collocation also facilitates referrals between behavioral health and physical health. The 2012 Annual QI Evaluation indicates that there is common coordination of care screening and referral form for formal requests. This was seen in the PH/BH file review.</p> <p>The QI Program Strategy indicates that members are surveyed regarding behavioral health needs across the existing quality programs.</p> <p>The 2012 Annual Evaluation describes weekly CCKY/MHNet team meetings and case management rounds offer additional opportunity for CCKY and MHNet staffs to interact.</p> <p>Finally, CCKY monitors behavioral health utilization indicators and there is MHNet input for the 2013 and 2014 PIPs.</p>	
<p>The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting</p>	<p>Minimal - The plan documented working on behavioral health and physical health coordination initiatives, including substance abuse among pregnant women and depression management by</p>	<p>Full</p>	<p>The QI Program Description reveals that behavioral health (BH) QI program is integrated into the plan's QI</p>	



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<p>from behavioral health integration into the Member's overall care.</p>	<p>PCPs. Onsite staff discussed tracking of referrals, PCP prescribing and depression screening. The plan did not provide reports of indicators relevant to behavioral health/physical health integration. The annual evaluation notes priorities for 2012 to include oversight of delegated services, including monitoring and improvement of behavioral health care delivery.</p> <p><b>MCO Response:</b> CoventryCares understands the importance of integrating behavioral health with physical health, and is committed to this important health initiative. CoventryCares is collaborating with its behavioral health subcontractor, MHNet, to ensure optimal outcome and continuity of care in the member's treatment related to major depression, pregnancy and drug abuse. This is partially accomplished through integration of MHNet and CoventryCares Case Managers in case rounds for those members needing both physical and behavioral health assistance.</p> <p>A focus study to address substance abuse in pregnant women and prevent medical conditions among newborns was proposed in late 2012. This is a collaborative project between Case Management, MHNet (behavioral health vendor), Medical Affairs, and Quality Improvement (QI). Prenatal substance abuse is a major public health concern nationally, and more specifically in Kentucky, and has potentially severe consequences for the user and their child. Substance abuse is defined as a pattern of excessive use of an illicit substance, such as drugs (marijuana, cocaine, heroin, methamphetamines, etc.), alcohol or nicotine and the over or misuse of prescription medications. Baseline data has been collected and community resources beyond case</p>		<p>program. MHNet provides regular representation in QI committees and workgroups. The plan monitors BH services through annual oversight audits.</p> <p>Major Depression PIP described BH and PH grand rounds meet weekly to assess high-risk patients with both behavioral and medical concerns in order to develop a plan of care. There is also a joint tracking tool used by plan case managers and MHNet. The resulting care coordination may have contributed to demonstrated improvement during the interim measurement.</p> <p>MHNet is also involved in the ED utilization PIP through joint case management services care coordination and development of case management tool.</p> <p>As per the 2012 Annual Evaluation, MHNet and CCKY case managers meet together for case rounds for those members requiring BH and PH services. The BH and PH case managers also refer members as needed for PH</p>	



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	<p>management are being explored. A workgroup has been established; goals and objectives have discussed and proposed. The full study proposal has been written and discussed to be implemented in year 2013. Please refer to attached proposal titled, "Focus Study-Substance use in pregnancy final 4.18.13." In addition, case rounds that include MHNNet and case management personnel for members having both physical and behavioral health concerns began in May 2013. Minutes are kept of the case rounds.(Minutes are available upon request).</p> <p>Our Performance Improvement Project (PIP) for Major Depression and Antidepressant Medication Management and Compliance is also working to address this issue and has progressed significantly in 2013. Please note, this PIP was updated and approved by the Department for Medicaid Services in December 2012. As a result, just a small data set was available for the EQRO review period. The interventions, monitoring and evaluation are occurring in 2013. In coordination with our behavioral health vendor, MHNNet, Case Management (CM), Provider Relations, the Pharmacy Director and the Medical Director are working on the following activities and initiatives since January of 2013:</p> <p>--Interdepartmental workgroup meetings started in December 2012 and are ongoing monthly. Minutes are taken and participants include QI, Outreach, Provider Relations, Case ManagementHealth Services, Medical Affairs and MHNNet, our behavioral health vendor. (Minutes available upon request).</p> <p>--The Academic literature search and strategies (PIP intervention #8) were implemented in collaboration with the Pharmacy</p>		<p>and/or BH issues. Completed referral forms were seen in the BH/PH Coordination file review.</p> <p>QMUM meeting minutes reflect joint reporting from case managers and MHNNet. QMUM also reviews BH collaborations such as prevention program focused on ADHD, Anxiety, Depression in the Older Adult, and post partum depression.</p>	



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	<p>Director and QI staff in January 2013. The goal of the collaboration is to develop strategies and identify literature to educate providers and assist them with educating their members regarding the adherence, response time to the medication, and the risks of premature discontinuation.</p> <p>--A targeted letter and brochure for 236 members was mailed in late January 2013 on the importance of following their treatment plan. Members were identified using the 2013 HEDIS methodology defined as members 18 years and older with a diagnosis of major depression and were newly treated with antidepressant medication.</p> <p>--The CoventryCares of Kentucky website is being enhanced to better educate members. The website will include a Behavioral Health a link to the National Institute of Mental Health (NIMH) website for depression. CoventryCares will use the member tab to provide members with educational information regarding the identification, diagnosis, and importance of management of major depression.</p> <p>--A PIP document library has been created. The library contains all the documents relating to the Major Depression Disorder (MDD) PIP (i.e. approved provider and member correspondence, reports etc.)</p> <p>--Kentucky transportation information has been distributed to all employees and members of CoventryCares and MHNNet. The transportation resource information will assist members with their transportation needs.</p>			



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	<p>--The Major Depression Disorder (MDD) PIP Intervention Tracking Tool has been created. The PIP Intervention Tracking Tool is a "living document" providing a current snapshot of all PIP activities tracking the internal flow process for referrals from CoventryCares Case Management (CM medical) to MHNet (behavioral services). Tracking will be ongoing. Updates will be presented to the MDD workgroup monthly.</p> <p>--Ongoing collaboration between CoventryCares and MHNet included the development of a tool for tracking mailings to members who receive education regarding depression and post partum depression. Results of the trackings are presented to the MDD workgroup monthly.</p> <p>--Development of a member educational packet to be mailed to members identified in the above tracking report. The packet includes a targeted member letter, <i>Following Your Treatment Plan</i> and <i>First Aid Tips</i> brochures, and a non-emergency room facts magnet.</p> <p>--Collaborated with the Quality Management and Compliance Committee (QMAC) for educating members in the community about major depression. This included a meeting in Georgetown, Kentucky on 3/31/2013. The MHNet keynote speaker's topic was "Mental Health Medication and Therapy."</p> <p>--HEDIS reports and Medication Possession Ratio rates evaluated monthly and will be reported in the next state quarterly report (please refer to report 19)</p>			



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	<p>--A total of 841 letters with brochures for following your treatment plan were sent to members in May 2, 2013, and 130 mailers to non-compliant members on May 30, 2013.</p> <p>We will continue our interventions and evaluation per our PIP work plan (please refer to PIP interventions outlined in the proposal), and a full evaluative report will be submitted to the state in September 2013 with HEDIS results.</p>			
<b>19.2 Annual QAPI Review</b>				
<p>The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to</p>	<p>Full - The Annual Evaluation of the Quality Improvement Program (Annual Review of Activities 11/1/11-12/31/11) was conducted after the plan had been in operation for two months, and is included in the Work Plan as an activity that will be conducted at the end of 2012. The 2011 Annual Review is dated 7/31/12. This evaluation includes an analysis of KY and Coventry population demographics. For the health plan, children ages 18 or less comprised 61% of the population, special needs (SSI) 17.8% and dual eligible 13%. An analysis of high volume episodes by diagnosis and place of service is also included; the top 20 diagnoses for high volume episodes include hypertension, asthma, diabetes and COPD. These conditions were therefore targeted for disease management. High risk OB was also identified as high volume.</p> <p>Abandoned calls and speed to answer were reported in the evaluation, and were noted to exceed the target in December; this was attributed to new staff and start up, and continued monitoring was planned. There were few other indicators to</p>	Full	<p>The 2012 Annual Evaluation reviews activities for the period between Jan 1, 2012 to December 31, 2012. The evaluation provides an in depth overview of the QAPI program. It includes a population analysis, which reveals that the plan covers about 24% of the entire KY Medicaid population.</p> <p>Children ages 18 years and under represent 64% of the membership.</p> <p>Linguistics analysis showed 3,000 Spanish-speaking members in their database. The plan, in turn, developed Spanish tag lines on all member mailings and translated mailers to each identified Spanish-speaking member. Translation services are offered</p>	



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<p>assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report by July 31 of each contract year.</p>	<p>report, given the short time that the plan had enrolled members; few complaints and grievances had been reported. Some examples of adverse events were included in the evaluation, and it is noted that these will be tracked and trended.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should consider root cause analysis of common adverse events.</p>		<p>through the toll free phone number as described in the Member Handbook. Language assistance services, TDD services, and person-to-person interpretation services are also available.</p> <p>High volume episode reporting is reported as a way to identify clinical priorities. The top 25 diagnoses included ADHD, COPD, acute URI, asthma, low back pain, diabetes and hypertension. The plan compared the high volume diagnoses with those of the high volume ED visits and found commonalities that will be addressed in the 2013 PIP – ED Utilization. The Disease Management programs focus on 6 diseases: asthma, diabetes, coronary artery disease, chronic kidney disease, heart failure, and COPD. An ADHD focused PIP was designed in collaboration with MHNNet.</p> <p>Access to Care was analyzed. This included a review of customer service, language line access, 24 hour nurse line use, appointment wait times, and network/geographic availability. As a result, CCKY conducted additional staff</p>	



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			<p>training, evaluated of McKesson (nurse line vendor) performance, improved the disease management program, changed the vendor used for the secret shopper Access/Availability (A/A) survey, and recruited additional providers in rural regions.</p> <p>Member satisfaction was assessed using the CAHPS survey. Results were not available at the time that CCKY prepared the 2012 QI program evaluation report. Grievances were analyzed. The top categories were: customer service, quality of care, and quality of service. CCKY planned to address these issues with additional training and education, a new electronic Grievance/Appeal (G/A) filing system, and a new Quality Check program for grievance processing.</p> <p>Evaluation of Clinical Care included a review of UM telephone access and CCKY met the metrics. To maintain the performance, CCKY developed a monitoring program to evaluate the representatives' accuracy, courtesy and responsiveness. CCKY noted a decrease in authorization requests</p>	



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			<p>which was attributed to refining the prior authorization list and educating providers.</p> <p>An analysis of bed days prompted CCKY to promote timely discharge and enhance the High Risk OB and Case Management programs.</p> <p>UM denials were reviewed. This revealed the need to direct members to in-network providers.</p> <p>Inter-rater reliability testing of UM reviewers was found to be very good and was followed by reinforcing the application and interpretation of UM criteria.</p> <p>CCKY planned to use monthly HEDIS measure performance reports to inform ongoing interventions. For services not assessed by HEDIS, the Kentucky-specific measures were to be used. CCKY planned to initiate provider feedback regarding HEDIS performance and non-compliance with guidelines through the provider targeted website – directprovider.com.</p>	



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			<p>Two PIPs were in process during 2012. The topics were priority areas for the state, Antidepressant Medication Management and Compliance, and Decreasing Non-emergent/ Inappropriate ED Utilization. CCKY formed multidisciplinary workgroups to design and monitor the PIP interventions. These workgroups included representatives of MHNet (BH vendor). The PIP results were not available at the time of the 2012 CCKY QI program evaluation report.</p> <p>Due to the first HEDIS and performance measure reporting to occur in 2013, there was no Pay-for-Performance program.</p> <p>In 2012, CCKY identified over 31,000 members for their disease management programs. The effectiveness and satisfaction of the disease management programs will be evaluated in 2013.</p> <p>Medical record audit prompted CCKY to educate and encourage providers to promote advanced directives and practice BMI assessment and</p>	



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			<p>documentation. Follow-up audits are scheduled in 2013.</p> <p>The 2012 Annual Evaluation describes delegation oversight findings and corrective action as necessary. The plan engages vendors for behavioral health, chiropractic, dental, pharmacy, 24 hour nurse line, and pain management services. They also use vendors for external review, and radiology utilization management services.</p> <p>Quality of care issues and adverse events are monitored monthly. The highest rate was seen in the second quarter. This may have been the result of CCKY implementing a new reporting system. Hospitals had the highest number of quality referrals due to surgical site infections.</p> <p>CCKY documented several activities to ensure continuity and coordination of care. MHNet is highly integrated in activities that involve BH concerns. A provider satisfaction survey was fielded in 2012. The survey demonstrated that areas of concern</p>	



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			<p>included: resolution of inquiries, claims payment process, service, and the authorization process. Interventions include: training call center staff, educating providers on policies and procedures, promoting directprovider.com, publishing information in the provider newsletter, and increasing outreach visits to providers.</p> <p>The Health Outcomes Survey is planned for 2013.</p>	
<b>21.3 External Quality Review</b>				
<p>The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.</p>	<p>Substantial - As per the plan's 2012 QI Program Strategy, Coventry participates in annual reviews and provides access to the site, information, documentation and dates for review to the EQRO. The plan provided most of the requested information for the annual compliance review; some information, such as Health Risk Assessment files, was not provided for review onsite or immediately thereafter. The plan provided PIP proposals and revised proposals as requested for PIP validation. Though not yet applicable, the corporate plan also reviews the annual EQRO evaluation, provides comments for improvement and implements EQR recommended corrective actions as per the Program Strategy.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should provide requested documentation in a timely</p>	<p>Substantial</p>	<p>The QI Program Description states that the plan will actively participate in an external independent review performed by the designated External Quality Review Organizations (EQRO), including providing the EQRO with access to site, information, documentation and data. Following an EQRO review the CCKY will review the EQRO report, provide comments for improvement, and implement corrective actions as recommended by the EQRO.</p> <p>During the onsite review, CCKY was</p>	<p>As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.</p>



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	fashion for future reviews.		<p>cooperative and helpful in providing documentation requested for clarification and in answering related questions. CCKY posted all follow-up documentation timely, most during the onsite.</p> <p>For some of the file reviews (Credentialing, HRA, Service Plans) some evidence/supporting documentation was not in the files or available. See the respective tools for detailed findings.</p> <p>In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely.</p> <p><b><u>Recommendation for CCKY</u></b> In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should</p>	



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			document the efforts taken to obtain the information.	
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.	Full - As per the QI Program Strategy, the plan actively participates in EQR activities. The health plan cooperated and participated in the evaluation of quality program review in October 2012, annual compliance review 2013 and the PIP validation process. The plan had key staff available for the onsite review, and staff was actively engaged in the process. The plan submitted PIP proposals, and engaged in conference calls to discuss findings and recommendations from review of the PIP proposals, and revised the PIPs based on recommendations.	Full	The QI Program Description states that CCKY will actively participate and make available all data, clinical and other records/reports to the state Medicaid agency for EQR activities.  CCKY cooperated and participated in the current compliance review, PIP validation, PM validation, requests for data and records for focused studies and other EQRO tasks and was cooperative with recommendations and suggestions.  For the onsite review, staff was readily available, helpful and responsive.	
<b>21.4 EQR Administrative Reviews</b>				
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of	Substantial - As per the QI Program Strategy and P/P QI-002, the plan provides information as requested for EQR activities. The plan provided most information requested as noted above; however, Health Risk Assessment member files that were requested were not provided for review.  <b>Recommendation for Coventry Cares</b> The plan should ensure complete submission and availability of requested documentation.	Substantial	As noted previously and in the QI Program Description, CCKY provided pre-site documentation as requested for the compliance review. There were some issues, documented above, with file review documentation (Credentialing, HRA, and Service Plans).  CCKY also cooperated with submission	As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and any challenges that may inhibit the plan from receiving the files.



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the Contractor.			<p>of data, records, and documents for other EQR activities, including PIP validation, PM validation, and focused studies.</p> <p>In the prior review, there were some issues related to timely submission of pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely.</p> <p><b><u>Recommendation for CCKY</u></b> In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.</p>	
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	<p>Substantial - As above, the plan assisted in EQRO reviews and evaluation. Some requested files and documents were not provided.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should ensure complete submission and availability of requested documentation.</p>	Substantial	<p>As described above, CCKY assisted in EQRO reviews and evaluation. There were some issues related to requested files.</p> <p>In the prior review, there were some issues related to timely submission of</p>	As Coventry transitions to the Aetna platform our annual review of policies and procedures will ensure staff is informed of requirements for timely access to files and timeliness of delivery to the EQRO. CCKY shall document its efforts to obtain files and



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			<p>pre-site documentation. IPRO recommended that CCKY provide the requested documentation in a timelier manner. For the current review, the pre-site documentation was received timely.</p> <p><b><u>Recommendation for CCKY</u></b> In the future, CCKY should provide all supporting documentation for the file reviews whether it is maintained at the local site or at other locations. If documentation is pursued but not provided by other parties, CCKY should document the efforts taken to obtain the information.</p>	any challenges that may inhibit the plan from receiving the files.
<b>21.5 EQR Performance</b>				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - The initial PIP proposals were not accepted by DMS, and the plan revised the proposals as per the timeline established during conference calls. The plan has not yet had opportunity to respond to findings of the compliance review.	Full	For the prior compliance review, CCKY provided responses for findings that were less than fully compliant, as required. In addition, CCKY revised its PIP proposals in response to EQR recommendations.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;	NA - EQR compliance review findings have not yet been provided to the plan. The assignment of a staff person to conduct review	Full	CCKY designated staff liaisons for follow-up for the EQR activities and	



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	findings follow-up is included in P/P QI-002. Responsible parties for PIP reviews were identified.		was cooperative with recommendations and requests.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and	NA - EQR compliance review findings have not yet been provided to the plan. As per P/P QI-002, the Quality Manager informs the Quality Management Committee of EQRO findings and will develop, implement and monitor a corrective action plan.	Full	The QI Work Plan and quarterly reports document that the Quality Manager informs the EQIC Committee of EQRO findings and develops, implements and monitors a corrective action plan.  The QI Work Plan indicates that the prior compliance review report was shared with EQIC in May 2013.	
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.	NA - This is included in the QI Program Strategy and P/P QI-002. The plan has not yet had opportunity to respond to findings.	Full	The QI Program Description states that CCKY will submit a Corrective Action Plan, within the timeframes established by the EQRO, to resolve any performance or quality of care deficiencies identified during any ongoing monitoring and assessment activities of the EQRO.  CCKY acted accordingly for the prior compliance review.	
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	NA - The QI Program Strategy describes the plan's participation (corporate participation is noted) in the annual external quality review, and includes implementation of corrective actions as per recommendations. The QI Work Plan includes cooperation with EQR activities. The QI Work Plan notes resubmission of PIP proposals based on EQR recommendations and formation of	Full	The QI Program Description states that CCKY will participate in the annual external quality review, including implementing corrective actions as per recommendations.	



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improvement during the term of this contract; and	interdepartmental work groups to address PIPs. The plan has not yet had opportunity to review annual compliance review findings.		The QI Work Plan incorporates cooperation with EQR activities. The QI Work Plan includes resubmission of PIP proposals based on EQR recommendations and formation of interdepartmental work groups to conduct PIPs.  CCKY has followed EQRO recommendations related to PIPs, focused studies, and compliance findings.	
E. If contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	NA - This is included in P/P QI-002. The plan has not had opportunity to review EQRO findings for the annual compliance review.	Not Applicable	Not applicable – CCKY has not indicated disagreement with EQRO findings.	
<b>19.3 QAPI Plan</b>				
The Contractor shall have a written QAPI work plan that	Full - The plan submitted the CoventryCares of Kentucky QI Work Plan 2012 (the Work Plan) final 7/25/12 updated 11/27/12.	Full	CCKY submitted the CCKY QI Work Plan 2013 (the Work Plan).	
outlines the scope of activities and	Full - Initiatives are listed in the Work Plan, with rationale and description of methodology for conducting and measuring initiatives.	Full	The QI Work Plan lists activities with rationale for selection and corresponding NCOA accreditation requirement. The QI Work Plan includes objectives, list of tasks, responsible staff, and benchmarks, due dates, status, and comments on project status.	



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			<p><b><u>Recommendation for CCKY</u></b> CCKY should include all action plans described in the Annual Evaluation, listing each by topic.</p>	
the goals,	Full - The Work Plan includes specific goals.	Full	The QI Work Plan includes specific goals.	
objectives, and	Full - The Work Plan includes specific objectives.	Full	The QI Work Plan includes specific objectives.	
timelines for the QAPI program.	<p>Substantial - Reporting frequencies are included in the Work Plan. Dates are included in the Work Plan, but it is not clear whether these are target dates for completion or dates that activities were completed.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The Work Plan should include anticipated timelines for the Program as well as completion dates. Responsible parties are identified in the work plan.</p>	Substantial	<p>The QI Work Plan incorporates start and due dates but it is not clear whether these are the target dates for completion or completion dates. The work plan does not include the dates when required reports were submitted to DMS and the internal committees.</p> <p>For the prior review, IPRO recommended that CCKY include timelines and completion dates in the QI Work Plan. As noted above, this was partially addressed as it is not evident if the dates are target or actual completion dates.</p> <p><b><u>Recommendation for CCKY</u></b> CCKY should label the dates as start, target, and actual completion dates</p>	The work plan for 2014 captures a Start date and a due date. A column for 'Completion Date' has been added for clarity at the request of IPRO. Additionally, the comments section will outline the report submission date to DMS and a report schedule will be attached to the work plan to capture specific deliverable dates for QMUM and EQIC reports.



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			and include submission dates for the required committee reports and DMS.	
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>NA - The Work Plan was finalized 7/25/12, and activities and status are updated quarterly in quarterly reports. There are few findings available as of yet, as the plan has not yet reported annual measures, conducted surveys or received findings from the EQRO review. The QI Program Strategy indicates that recommendations will be developed based on annual review of the QAPI program.</p> <p>Committee minutes provide evidence of tracking and trending grievances and appeals and adverse events. As per EQIC minutes, the plan has set goals for appeal overturn rates. The plan is monitoring monthly HEDIS indicators, although annual results are not yet available to set goals.</p> <p>Interventions were outlined in response to Provider Survey results.</p>	Full	<p>The 2012 Annual Evaluation includes revised goals, objectives, and interventions for the coming year. Committee minutes provide evidence of tracking and trending quality improvement activities, survey results, grievances and appeals, performance measures, and adverse events.</p> <p>Since CCKY will report its first year HEDIS rates in 2014, there is no information on QI activities related to HEDIS performance in the 2012 QI Evaluation. However, CCKY provided other documents onsite that described the HEDIS measures being targeted for improvement and the related initiatives.</p>	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full - As per the QI Program Strategy, the Board of Directors has delegated oversight of the QI Program to the Executive Quality Improvement Committee, and responsibilities include review and approval of the QI Program Description and Work Plans, including updates to Work Plans, as per the QI Program Strategy and EQIC Responsibilities-2012 document provided by the plan. The EQIC approved the QI Program Strategy and QI Work Plan on 7/25/12 as reflected in minutes and the QI Work Plan. Discussion of the updated QI Work Plan is also evident in committee minutes and	Full	The QI Program Description states that the Board of Directors is responsible for the quality of care and delegates oversight of the QI Program to the EQIC. The EQIC responsibilities include review and approval of the QI Program Description and QI Work Plans, including updates.	



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	the Work Plan.		Discussion and approval of the QI Work Plan and QI Program Description is evident in EQIC minutes.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - The Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of Coventry Cares of Kentucky. As per the QI Program Strategy, the board has delegated oversight of the plan's Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC). The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer and includes members of senior leadership. The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. The Vice President of Medical Affairs (Medical Director) is the senior executive responsible for the Quality Improvement Program as per the QI program Strategy. The Regional Vice President of Quality Improvement provides direction on activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.	Full	As indicated above, the Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of CCKY.  The QI Program Strategy states that the Board of Directors (BOD) delegates oversight of the Quality Improvement and Management program to the Executive Quality Improvement Committee.  The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer and includes members of senior leadership.  The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight.  The EQIC also reviews and makes recommendations on QI studies,	



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			<p>surveys, indicators, interventions, progress in meeting goals and follow-up to findings.</p> <p>The Vice President of Quality Improvement (Medical Director) is the senior executive responsible for the Quality Improvement Program according to the QI program description. The Regional Vice President of Quality Improvement provides direction on activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.</p>	
<p>review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;</p>	<p>Full - The EQIC Description, Committees and Org Chart document provided by the plan notes that the EQIC reviews the QI Program Description, Work Plan and updates, and Annual Evaluation, and is responsible for monitoring delegated services and activities of other committees. As noted above, the Board of Directors annually reviews the Program Description, Work Plan and Program Evaluation, as described in the QI Program Strategy, and the EQIC reports to the Board of Directors as per the QI Program Strategy. The EQIC reviewed and approved the 2012 Quality Improvement Work Plan, Quality Improvement Program Strategy and the 2011 QI Program Evaluation on 7/25/12 as per meeting minutes. The plan also provided EQIC meeting minutes for March, June, July, August and September 2012 for review.</p>	<p>Full</p>	<p>The EQIC Description, committee descriptions, and Organizational Chart provided by CCKY show that the EQIC reviews the QI Program Description, QI Work Plan and updates, and the Annual QI Evaluation, and is responsible for monitoring delegated services and the activities of sub-committees.</p> <p>CCKY also provided quarterly committee reports and monthly EQIC meeting minutes for review.</p>	



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	<p>The 9/27 EQIC minutes indicates that the EQIC will receive biannual reports from each committee and that programs not meeting goals will be discussed in committee. The plan provided a detailed schedule of reports due from the QM/UM Committee and Service Advisory Committee. The agenda for the 11/2012 EQIC meeting notes that the EQIC will review grievances and appeals, however minutes were not provided for this meeting. The EQIC also reviewed and approved PIP proposals on 8/29/12.</p>		<p>The Board of Directors reviews the QI Program Description, QI Work Plan and Annual QI Evaluation annually.</p> <p>The QI Program Strategy indicates that the EQIC reports to the Board of Directors. The EQIC approved the QI Program Description and QI Work Plan on 5/22/13 as reflected in committee minutes and the QI Work Plan. CCKY report on 4/30/13 showed EQIC will receive biannual reports from each committee and that programs not meeting goals will be discussed in committee.</p> <p>There is documentation that the EQIC oversaw all audits, surveys, corrective action plans, NCQA accreditation preparation, QI initiatives/studies, and required QI reports and summaries.</p>	
<p>review on an annual basis of the QAPI program; and</p>	<p>Full - As per the QI Program Strategy, the EQIC reviews and approves the QAPI program evaluation. The minutes of 7/25/12 reflect approval of the 2011 QI Annual Review by the EQIC. The EQIC also reviews the program strategy and Work Plan as documented in committee minutes.</p>	<p>Full</p>	<p>CCKY provided the 2012 Annual QI Evaluation report. Quarterly reports and meeting minutes show that EQIC reviewed and approved the 2012 Annual Evaluation, QI program description and QI Work Plan.</p>	
<p>modifications to the QAPI program on an ongoing basis to accommodate review</p>	<p>Substantial - As noted in the QI Program Strategy, the EQIC reviews quality improvement studies, surveys, indicators and</p>	<p>Full</p>	<p>The 2012 Annual QI Evaluation highlights opportunities for</p>	



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findings and issues of concern within the organization.	<p>intervention and makes program recommendations based on findings. The QI Work Plan reports 17 submitted quarterly include activities and interventions based on findings of monitoring activities. Areas addressed include customer service call metrics, access, high level complaints and grievances and sentinel/adverse events. Other activities are noted for EPSDT and other quality indicators in quarterly reports. Since there was little to report in the 2011 annual program evaluation due to the short timeframe of member enrollment, the 2012 Program Strategy had little to incorporate from the annual program evaluation. HEDIS and Healthy Kentuckian indicators have not yet been reported.</p> <p>Some areas of concern such as Health Risk Assessment completion, access issues in some regions of the state, and EPSDT screening rates did not have corresponding activities noted in documents provided. Some activities reported onsite, though not yet included in the Work Plan, include addressing access by mapping and increasing urgent care centers and identifying providers who would take members out of panel; formation of a work group regarding Health Risk Assessments; development of EPSDT report cards for providers and an EPSDT training module; and providing feedback to providers on a medical record audit. Some of these activities are documented in committee minutes and others occurred after the review period.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should ensure these activities are included in future Work Plans.</p>		<p>improvement and action plans for monitored topics within the QAPI program.</p> <p>The 2013 Work Plan is organized by rationale for selection, including accreditation requirement, contract requirement, or EQRO review findings. The QI Work Plan now includes a column for comments where descriptive updates are provided. Additionally, committee meeting minutes provide detailed information.</p> <p>For the prior review, IPRO recommended that, in the future, CCKY should ensure these all areas of concern and the activities are included in the QI Work Plan. For the current review, although EPSDT initiatives were not included in the QI Work Plan, CCKY indicated that there is a dedicated work plan for EPSDT.</p> <p><b><u>Recommendation for CCKY</u></b> CCKY should consider referencing the EPSDT work plan in the QI Work Plan or including as an attachment.</p>	
The Contractor shall have in place an	Full - As per the QI Program Strategy and EQIC Description,	Full	The QI Program Description states the	



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<p>organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.</p>	<p>Subcommittee and Org Chart document, and as noted above, the Board has delegated oversight of the plan's QI program to the Executive Quality Improvement Committee (EQIC). The EQIC implements, monitors and evaluates the effect of quality improvement policies, procedures and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings. All quality improvement activities and subcommittee recommendations are reported to the EQIC for assessment, development, implementation and monitoring of activities. Several subcommittees are identified in the QI Program Strategy, including the Quality Management/Utilization Management, Service Advisory, Compliance, Credentialing, Quality and Member Access, and Pharmacy and Therapeutics Committees; these committees routinely report to the EQIC. The EQIC Description, Subcommittee and Org Chart document and EQIC meeting minutes document that the EQIC monitors all aspects of the QAPI Program.</p> <p>As per the Program Strategy, the Quality Management/Utilization Management Committee (QM/UM) is the committee that provides clinical input and physician review of QI and UM programs and provides recommendations for the programs to the EQIC. The Vice President of Medical Affairs chairs the QM/UM committee. Minutes reflect clinical review of the QI and UM programs.</p>		<p>Board of Directors of Coventry Health and Life Insurance Company is ultimately responsible for oversight of the QI Program of CCKY. The BOD delegates oversight of the Quality Improvement and Management program to the Executive Quality Improvement Committee (EQIC).</p> <p>The EQIC reports to the Board of Directors, is chaired by the Chief Executive Officer, and includes members of senior leadership.</p> <p>The EQIC implements, monitors and evaluates quality improvement initiatives and programs; quality of care and services; credentialing; utilization management and delegated services oversight. The EQIC also reviews and makes recommendations on QI studies, surveys, indicators, interventions, progress in meeting goals and follow-up to findings.</p> <p>The Vice President of Quality Improvement (Medical Director) is the senior executive responsible for the Quality Improvement Program. The Regional</p>	



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			<p>Vice President of Quality Improvement provides direction for the activities of the Quality Improvement Department. The Regional Director/Manager of Quality directs the operational components of the QI Program.</p> <p>The Program Strategy indicates that the Quality Management/Utilization Management Committee (QM/UM) provides clinical input and physician review of QI and UM programs and makes recommendations to the EQIC.</p> <p>The Vice President of Medical Affairs chairs the QM/UM committee. Committee meeting minutes reflect clinical review of the QI and UM programs.</p>	
<p>The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.</p>	<p>Full - As per the QI Program Strategy, and as reflected in minutes, the EQIC is comprised of senior leadership staff across departments who are involved in QI Program activities, such as the VP of Medical Affairs, Health Services, Compliance, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals. Participation across departments is evident in committee minutes. The QM/UM Committee is the subcommittee of the EQIC that includes physician representation; in addition to two plan medical directors, three network providers and MHNNet are represented on the committee. QM/UM minutes identify</p>	<p>Full</p>	<p>The quarterly reports, and committee meeting minutes demonstrate that the EQIC is comprised of senior leadership staff across the organization participate in QI Program activities. These include the VP of Medical Affairs and the Health Services, Compliance, Pharmacy, Community Development, Provider Relations, Network Operations, Behavioral Health, Quality and Appeals departments.</p>	



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	<p>membership from internal medicine and pediatrics as well as behavioral health and hospital representation. Onsite staff noted that representation from obstetrics/gynecology was still being recruited. Network provider input was evident in committee minutes. The QM/UM committee had its inaugural meeting September 20, 2012 and met monthly thereafter in 2012.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should continue attempts to recruit an obstetrics representative.</p>		<p>Participation across the organization is evident in committee meeting minutes. The QM/UM Committee is a subcommittee of the EQIC that includes physician representation. The CCKY medical directors, three network providers and MHNet are represented on the committee. QM/UM minutes identify membership from internal medicine and pediatrics as well as behavioral health and hospital representation.</p> <p>In the prior review, IPRO found that CCKY was still seeking OB/GYN provider(s) to participate in the committee. For the current review, CCKY still had not located an OB/GYN to join the committee. Onsite staff indicated that potential participants were being sought from Partners in Women's Health in Louisville and the Department of OB/GYN at UK in Lexington.</p>	
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to	Full - The plan provided agendas and minutes for EQIC meetings from March 28, June 13, July 25, August 29 and September 5, and September 27 of 2012. An agenda was provided for November 14, 2012, although meeting minutes were not. The QM/UM	Full	CCKY provided monthly committee meeting minutes for the EQIC and QMUM committees. These were included in the quarterly reports.	



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the Department upon request.	committee met initially on September 20, 2012 and monthly thereafter in 2012; meeting minutes were provided for QM/UM meetings on September, October, November and December of 2012.		The activities of the EQIC were documented in the comments area of the QI Work Plan.	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	Full - Reports of QI activities relevant to providers are reported to the EQIC annually or more frequently as per the EQIC Description, Subcommittees and Org Chart, and the EQIC is responsible for integration these activities related to providers as well delegation oversight. Minutes of the QM/UM Committee include multiple examples of QI activities relevant to providers and subcontractors, such as clinical guideline dissemination, evaluation of dental decay data, medical record audit for BMI and advanced directive documentation, creation of EPSDT toolkits and audit forms, MHNet training materials and plans for hospital site visits to discuss criteria for utilization reports. The Provider Manual includes requirements for provider agreement to participate in quality improvement activities s including site visits and medical record audits and encounter record submission. These are included in the Provider Manual for delegated services as well. As documented in the QI Program Strategy, the Compliance Committee oversees subcontractor relationships and also oversees the Delegation Oversight Committee. The first meeting of the Delegation Oversight Committee occurred on 9/27/12 as per EQIC minutes, and this committee reports to the EQIC. Minutes for this committee meeting were not provided. Behavioral health has its own quality program, but appears well integrated with physical health as described above.  Quarterly report 15 in the second quarter documents feedback to	Full	As seen in the EQIC Description, provider and subcontractor QI activities are reported to the EQIC annually or more often.  The EQIC is responsible for integration of activities related to providers as well delegation oversight. Minutes of the QM/UM Committee include multiple examples of QI activities relevant to providers and subcontractors, such as clinical guideline dissemination, disease management programs, prescription policies, creation of EPSDT toolkits and audit forms, peer review, provider survey results, authorizations/denials, professional organization recommended guidelines, PIPs, HRA reports, HEDIS results and benchmarks, QOC reports, Medical record review audits, MHNet collaborations, and plans for hospital site visits to discuss criteria for utilization reports. The Provider Manual includes requirements for provider agreement to participate in	



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	<p>the dental, behavioral health and pharmacy subcontractors regarding compliance and grievances and appeals. As per the encounter data questionnaire submitted to the EQRO, Coventry conducts audit and validation of provider claims. Evidence of feedback to providers was provided in QM/UM minutes (medical record audits).</p>		<p>quality improvement activities including site visits and medical record audits and encounter record submission. These are included in the Provider Manual for delegated services as well.</p> <p>As documented in the quarterly CCKY reports, the Compliance Committee oversees subcontractor relationships. The Delegation Oversight Committee reports to EQIC and monitors the performance of subcontractors.</p> <p>Behavioral health has its own quality program, but appears well integrated with physical health as described above.</p>	
<p>The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.</p>	<p>Full - The plan's QI Work Plan, QI Program Strategy and UM Program Description include Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities.</p> <p>Provider Credentialing is incorporated into QI activities relative to quality of care concerns and adverse event monitoring. Provider Services is part of QI activities outlined in the QI Work Plan. Evidence of inclusion of these management activities is also present in EQIC minutes and member lists.</p>	<p>Full</p>	<p>CCKY's QI Work Plan, QI Program Description and UM Program Description include Utilization Management, Risk Management, Member Services, and Grievances and Appeals in QI activities.</p> <p>As of November 1, 2013, under Aetna, the CCKY Credentialing Committee was retired and Aetna National Quality Management and Measurement Department assumed responsibility.</p>	



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			<p>CCKY will continue local management of the issues list, contracting and other provider relations functions and delegation oversight agreements in the Network Management Department. Delegation auditing will be shared between CCKY and Aetna. However, provider quality of care issues and overall performance will be incorporated in re-credentialing. Since the MCO is new, no providers have gone through re-credentialing.</p> <p>CCKY continues its transition to Aetna national processes and will be fully integrated in 2015.</p>	
<p>Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of Member's care and services, including those with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving members in QAPI initiatives and conducting performance</p>	<p>Full - The local MCO QI team is noted in the QI Program Strategy to include the Vice President of Medical Affairs, plan medical directors, the Manager of Quality Improvement, four QI Coordinators and one QI Analyst. Case Management, Medical Management and Member Appeals staff also participates in QAPI activities. The Regional VP of Quality Improvement for the Medicaid Region (Kentucky, Michigan and Missouri) is active in EQIC meetings, and as per EQIC minutes oversees the Kentucky Quality Improvement management team. During onsite discussion in October, the plan identified an EPSDT Case Manager as a key vacancy; this position has now been filled as per onsite staff during the compliance review. The Behavioral Health Director and Medical Director and behavioral health care advocates are co-located at the health plan. The health plan staff</p>	<p>Full</p>	<p>At the corporate level, the Board of Directors and the Board of Managers delegates responsibility for the quality improvement process to the Corporate Quality Improvement Committee (CQIC). CCKY's Chief Medical Officer (CMO) has overall responsibility for the Corporate QI Program. The corporate Medical Director is the designated physician for the QI Program, has oversight of the program and is an active member of the CQIC. The Corporate Vice President of QI leads the activities in the QI Department.</p>	



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<p>improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.</p>	<p>includes a social worker behavioral health-physical health liaison. The plan has onsite hospital concurrent reviewers. Corporate plan resources include Medical Directors, Corporate VP of Quality, QI Managers, IS support and Member Services as per the QI Program Strategy. Regional resources include the Vice President of QI, Director of Quality and HEDIS Manager.</p> <p>Coventry Cares meets actively with corporate staff. Monitoring and evaluation is effectively implemented as described below.</p>		<p>The Corporate Sr. Vice President and other Corporate QI staff participate in the QI Program.</p> <p>At the regional level, the Regional Quality Vice President and Regional QI Coach/Chief Executive Officer have overall responsibility for the Regional QI Program. The Regional QI Vice President reports directly to the Regional QI Coach. The Regional Quality Improvement Director manages the day-to-day activities of the QI Program and reports directly to the Regional Vice President of Quality Improvement. Regional QI Department Staff are responsible for implementation, analysis and reporting on QI activities. Health Plan Senior Medical Directors participate in the Regional Quality Improvement Committee.</p> <p>Locally, the CMO and VP of Medical Affairs are responsible for directing the QI programs. Medical Directors are responsible for medical management programs. The Director of Health Services ensures staffing levels and staff competencies. Managers and</p>	



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			<p>supervisors oversee day-to-day activities. QI Program staff includes clinical and professional staff supported by Medical Directors and staff from the following departments: UM and QI, Network Management, Provider Relations, Compliance, IT support and Member Services. Analytic Resources encompass multiple experienced QI personnel, data analysts, certified coders, Information Systems and actuarial experts.</p> <p>Behavioral health QI activities are integrated into the QI program with a doctorate-level behavioral health practitioner serving as a member of the Corporate QI Committee and the Regional Physician Advisory Committee.</p> <p>The EQIC committee is comprised of a multidisciplinary membership, including: Medical Directors, BH, pharmacy, Network Management, Service Operations, and Health Services Directors, and Managers of Appeals, Compliance, and Provider relations.</p>	



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			This structure will likely change for 2015 as CCKY becomes more integrated into the Aetna model.	
<b>19.4 QAPI Monitoring and Evaluation</b>				
<p>A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.</p>	<p>Full - The Annual Program Evaluation, quarterly reports and committee minutes provide evidence of ongoing monitoring of quality of care. Enrollment in Disease Management and Case Management is monitored, and gaps in care for members with chronic conditions or missing services are monitored by the plan as per quarterly reports. Relevant HEDIS measures will also be monitored for these members. The plan is monitoring substance abuse among pregnant women and antidepressant medication management. The plan has begun monitoring monthly administrative HEDIS rates, as per plan staff onsite, although reports were not available for review. The plan monitors Geo Access, EPSDT screens, Health Risk Assessment completion, utilization data and member complaints and grievances. The plan conducted an audit of provider documentation of BMI and Advance Directives. Activities have been implemented relative to the findings. The plan is to begin provider appointment availability secret shopper calls in 2013.</p> <p>The plan will begin to implement a Key Performance Indicator log to establish baseline data, which will be reviewed by the EQIC. Indicators for this log include Customer Service and Language line Access, Member and Provider Grievances and Appeals, Network Additions and Credentialing, Authorizations, Utilization – bed days, average length of stay, readmission rates, high volume</p>	Full	<p>The 2012 Annual Evaluation and quarterly reports provide evidence of ongoing monitoring of quality of care. The 2012 Annual Evaluation describes monitoring activities and results focused on special needs, acute or chronic physical or behavioral conditions, high volume, and high risk populations, in the population analysis. The population analysis highlights opportunities for improvement and action plans.</p> <p>The QMUM committee minutes show evidence of development of practice guidelines, development of performance improvement goals and case management initiatives, oversight of PIPs, utilization reports, grievances and appeals, and nurse line protocols and reports. There is evidence of monitoring of quality of care concerns and sentinel events in committee minutes.</p>	



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	<p>diagnosis, Utilization by place of service, ER Utilization, Case Management access and case intensity levels, Outreach initiatives, Disease Management enrollment by disease category, Adverse Events and Quality of Care concerns.</p> <p>The plan's P/P QI-009 outlines monitoring, investigation and trending of adverse events from a variety of sources, and the QI Work Plan documents that adverse events and potential quality of care concerns are tracked, trended and reported annually. There is evidence of monitoring of quality of care concerns and sentinel events in committee minutes. Committee minutes for the EQIC indicate that improvement of coding of quality of care concerns is being worked on to improve trending ability, since currently it is difficult to identify trends. Quarterly reports also indicate that appeal overturn rates are monitored and as per committee minutes, the top ten appeals will be evaluated. CAHPS member survey will be conducted in 2013.</p> <p>The plan has analyzed member demographic data and diagnosis prevalence to prioritize quality improvement activities and focus disease management programs as per the QI Program Evaluation.</p> <p>The QI Work Plan includes monthly monitoring of customer service and pharmacy call metrics (abandonment, speed of answer), nurse line calls, and utilization management calls (prior authorization), and these appear to be actively monitored.</p> <p>As per MCO quarterly report 18, behavioral health network provider: enrollee ratios and service utilization are being tracked. The plan is working on clarification for some behavioral health</p>		<p>The 2012 Annual Evaluation documents that adverse events and potential quality of care concerns are tracked, trended, and reported annually.</p> <p>The plan has analyzed member demographic data and diagnosis prevalence to prioritize quality improvement activities and focus disease management programs as per the 2012 Annual Evaluation.</p> <p>The QI Work Plan includes monthly monitoring of customer service and pharmacy call metrics (abandonment, speed of answer), nurse line calls, and utilization management calls (prior authorization), and these appear to be actively monitored.</p> <p>The plan coordinates improvement initiatives with MHNNet, such as PIPs covering Major Depression, ED Utilization, and hospital readmissions. Other BH collaborations include prevention program focused on ADHD, Anxiety, Depression in the Older Adult, and post partum depression.</p>	



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	<p>metrics.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should continue work on improving trending of quality of care concerns by improving categorization and monitoring detailed types of concerns.</p>		<p>In 2012, CCKY conducted a review of medical record keeping practices. Two indicators did not achieve the goal of 80% compliance: documenting BMI and Advance Medical Directives. CCKY implemented interventions and the follow-up review was conducted.</p> <p>In 2013, CCKY reported its first HEDIS and CAHPS rates. On site, CCKY provided a summary of the HEDIS measures to be targeted.</p> <p>In the prior review, IPRO recommended that CCKY should continue work on improving trending of quality of care concerns by improving categorization and monitoring detailed types of concerns.</p> <p>The 2012 QI Evaluation indicated that CCKY improved its processes for Adverse Events (AE) and Quality of Care (QOC) issues. P/P and training improved the MCO's ability to effectively refer, categorize, review and analyze AEs and QOCs. As a result, CCKY identified that post-up infections were an issue. CCKY conducted a</p>	



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			focused study and implemented an improvement plan.	
<p>B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.</p>	<p>Full - Clinical and preventive guidelines are included in the EQIC Description and QI Program Strategy. EQIC and QM/UM committee minutes include discussion of clinical guidelines. The plan presented USPSTF Preventive Health Guidelines to the EQIC on June 13, and behavioral guidelines were reviewed by the EQIC on 8/29/12. The QM/UM committee discussed disease management guidelines, notification of providers regarding these guidelines and ADHD guidelines as per committee minutes. The QM/UM committee at the 9/20 meeting conducted peer review, and quality of care concerns and adverse events are investigated and evaluated by the plan Medical Director. The plan has conducted a medical record audit of BMI documentation and Advance Directives, and began monthly monitoring of HEDIS measures, which will be reported in June 2013. Provider compliance with guidelines monitoring will include monitoring of HEDIS measures as per the QI Program Evaluation.</p>	<p>Full</p>	<p>Clinical and preventive guidelines are included in the QI Program Description, EQIC and QM/UM committee minutes. QMUM meeting minutes from July 18, 2013 indicate a review of Behavioral Health Guidelines. Meeting minutes from April 18, 2013 indicate review and edit of Short-Term Chronic Opiate policy, AAP or ADA Dental Health Screenings, and review of CDC changes to immunization schedules; May 16, 2013 shows approval of the "Preventive Health Guide Lines"; December 19, 2013 indicates review of Clinical Policy Updates.</p> <p>Policy updates and clinical guidelines are posted on the online provider portal: directprovider.com. Updates are also communicated through newsletters as evidenced in Provider Newsletter volume 1 issue 2.</p> <p>Quarterly report 1/30/14 indicates that an annual medical record audit was performed and improvement efforts were implemented for</p>	



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			documentation of BMI and Advance Directives. Additionally, CCKY reported its first HEDIS rates in 2013. HEDIS is used to evaluate provider compliance with selected guidelines.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - A medical record chart audit was conducted for BMI and Advance Directive documentation, with feedback given to providers. HEDIS measures, which will be used to assess provider compliance with guidelines, have not yet been reported. However, as per quarterly report 18, providers are being informed of members with gaps in services based on monthly monitoring of selected HEDIS measures. As per QM/UM minutes, providers with referrals for Quality of Care concerns or adverse events are being tracked and trended. The plan identified that customer service calls did not meet goals, and actions and interventions planned were outlined in the activity summary of the Work Plan in quarterly reports. The plan indicated that EPSDT report cards for providers were being developed, and QM/UM Committee minutes indicate that an EPSDT audit form is being developed. EPSDT rates were noted to be below goal, and the plan implemented automated calls and mailings to address the low screening rates. A Health Risk Assessment (HRA) work group has been formed to address HRA completion. Areas with opportunity for improvement are noted in the Annual QI Evaluation, with associated improvement activities.	Full	As indicated above, CCKY conducted interventions related to documentation of BMI and Advance Directives with a 6-month follow-up review.  HEDIS measures were first reported in 2013 and onsite, CCKY provided documentation regarding the HEDIS measures that will be targeted for improvement (noted previously in this report). Gap reports posted to directprovider.com inform providers of members with gaps in services based on monthly monitoring of selected HEDIS measures and ED utilization has been added. Additionally, CCKY met with Aetna corporate regarding provider profiling initiatives and High Performance Networks (based on providers/groups that exceed goals).  As per QM/UM minutes, providers with referrals for AEs/QOCs are being tracked and trended, and a focused	



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			<p>study with subsequent interventions was completed.</p> <p>Regarding the HRA completion rate, please see the QAPI Structure and Operations Tool. Areas with opportunity for improvement are noted in the 2012 Annual Evaluation, with associated improvement activities.</p> <p>The Work Plan documents tracking of various improvement activities.</p>	
<p>The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.</p>	<p>Full - Effectiveness of interventions is monitored by ongoing tracking of indicators and provider quality referrals as noted above and as described in quarterly reports. There were no distinct provider-related corrective actions that appeared to be identified and monitored by the plan in the submitted documentation or discussion.</p>	<p>Full</p>	<p>EQIC meeting minutes on September 25, 2013 indicate corrective action plan was developed for a vendor as the result of findings on the delegation oversight summary report.</p> <p>Tracking of indicators via monthly HEDIS, PIPs, and performance measures among others is used to evaluate to assess the effectiveness of corrective actions and interventions.</p> <p>The QI Program Description and the 2012 Annual Evaluation state that the Delegation Oversight Committee develops corrective action plans and monitors improvements. MHNet</p>	



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			maintains its own Corrective Action Plans.	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full - The plan's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff. The QM/UM committee, which reviews and analyzes clinical data, includes pediatric, internal medicine, hospital and behavioral health members, as well as Case Management, Appeals, Health Services and Pharmacy representation. The plan is engaging all departments as it plans for HEDIS reporting. As per the QI Program Strategy, there is computer/data and clinical/professional staff at the local plan level and also at the corporate level to augment local staff for QI activities as per the QI Program Strategy. The behavioral health PIP is being conducted by a team that includes both MHNNet and plan staff.	Full	<p>The plan's EQIC membership is multidisciplinary and includes senior leadership from Quality Improvement, Provider Relations, Pharmacy, Health Services, Behavioral Health, Operations, Government Relations, the Medical Director, and others, including corporate staff.</p> <p>The QM/UM committee, which reviews and analyzes clinical data, includes pediatric, internal medicine, hospital and behavioral health members, as well as Case Management, Appeals, Health Services and Pharmacy representation.</p> <p>According to the QI Program Description, there is computer/data and clinical/professional staff at the local plan level and also at the corporate level to augment local staff for QI activities as per the QI Program Description. The behavioral health QI activities include collaboration between MHNNet and plan staff.</p>	
D. The Contractor shall submit to the	Full - At the time of the review, the plan had submitted quarterly	Full	According to the QI Work Plan, the	



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<p>Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.</p>	<p>MCO reports through January 2013 and two PIP topics, one behavioral health focused (Major Depression) and one physical health focused (Emergency Department Utilization). PIP activities are reported in quarterly reports number 19. PIP revisions as per EQR and DMS recommendations were submitted by the plan.</p>		<p>2013 QI Program Description and annual UM Program Evaluation were submitted to DMS in July 2013. Updates to the QI Program were sent to DMS on a quarterly basis.</p> <p>CCKY PIP topics include: (2103) Major Depression and ED Utilization and (2014) ADHD and Inpatient Readmissions.</p> <p>PIP proposals were revised and submitted based upon EQRO recommendations. 2013 PIPs were approved by DMS on 2/24/2014 and 2014 PIPs were approved by DMS on 3/4/2014.</p>	
<p>E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.</p>	<p>Substantial - As per the QI Program Strategy, the plan's evaluation of the QAPI Program includes evaluation of utilization and clinical performance data against evidence based practice. The Provider Manual describes clinical guidelines and where to locate them on the plan's website. The process for development, approval and distribution of review guidelines was described in the first quarterly reports #23, Evidence Based Guidelines for Practitioners. The plan did not provide a specific policy relevant to the development or adoption of clinical practice guidelines.</p> <p>Clinical review guidelines are included in the UM Program Description, which notes that they are available on request and are disseminated on the provider website, provider manual and</p>	<p>Substantial</p>	<p>According to the QI Program Description, CCKY's evaluation of the QAPI Program includes evaluation of utilization and clinical performance data against evidence based practice.</p> <p>The Provider Manual describes clinical guidelines and where to locate them on the plan's website.</p> <p>Guidelines are provided to members in the Member Handbook including EPSDT guidelines, routine</p>	<p>As a part of the CoventryCares and Aetna migration, CCKY will adopt the Aetna policy and procedures outlining development, adoption and dissemination of clinical practice guidelines.</p>



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	<p>provider newsletters.</p> <p>Committee minutes provide evidence of discussion of clinical practice guidelines. EQIC minutes of 7/25 include a report on an annual review of preventive health guidelines by the corporate Quality Team, and note that these guidelines are distributed to plans. The QI Work Plan includes annual review of clinical practice guidelines by the QM/UM Committee with recommendations to EQIC. Per the Work Plan, this review was completed by the EQIC in June of 2012, although the QM/UM Committee first met 9/20/12. QM/UM Committee minutes of 9/20 reflect discussion of Disease Management guidelines and planned voting on the guidelines by members; per the Work Plan these were distributed to providers on 9/30/12. ADHD guidelines were also discussed by the QM/UM. Preventive Health Guidelines are documented in the QI Work Plan as approved by the EQIC 6/27/12 and distributed to providers on 9/30/12. Per the QI Work Plan, the immunization schedule is also annually reviewed and distributed to PCPs and posted in the member and provider handbook. An updated immunization schedule adopted by EQIC on 8/29/12 was noted to be disseminated via provider website and provider notification via FAX as per meeting minutes. MHNet reviews behavioral health guidelines annually; these were approved by the EQIC on 8/29.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines.</p>		<p>testing/screening and cancer screenings. The member newsletters also include guidelines.</p> <p>QMUM meeting minutes note review of evidence based clinical guidelines and standards and the committee's input and oversight of disease management guides. These guides refer to guidelines established by professional entities and are available to providers on the website portal. Clinical review guidelines are included in the UM Program Description, which notes that they are available on request and are disseminated on the provider website, provider manual and provider newsletters.</p> <p>In the prior review, IPRO recommended that CCKY consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines. CCKY indicated that this is on hold due to the Aetna merger, which was announced October 2012 and was completed in May 2013, with full integration of CCKY's processes by Q1 2015.</p>	



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			<p><b><u>Recommendation for CCKY</u></b> The plan should consider developing policies/procedures for development, adoption and dissemination of clinical practice guidelines.</p>	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	Full - The Provider Manual describes the adoption of nationally recognized guidelines by the plan and sources such as the American Academy of Pediatrics. The plan references USPSTF preventive health guidelines and behavioral health guidelines adopted from the American Psychiatric Association (APA) in committee minutes and quarterly reports. USPSTF preventive health guidelines were presented to the EQIC June 13, 2012. The UM Program Description documents the use of InterQual guidelines for clinical decision-making. This document also indicates that medical necessity is determined based on scientifically based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by Coventry. An updated immunization schedule was approved by EQIC on 8/29/12.	Full	<p>Disease Management Guides site clinical evidence-based standards as recommended by nationally recognized professional organizations, such as the American Lung Association, National Heart Lung and Blood Institute, American Heart Association, and American College of Cardiology Foundation.</p> <p>QMUM Meeting minutes indicate that the CDC was used as a resource to review immunization updates and the American Academy of Pediatrics and the American Dental Association Dental Screening was reviewed.</p>	
consider the needs of Members;	Full - The UM Program Description notes that guidelines used in UM decision-making may be modified to consider an individual member's characteristics. EQIC minutes of 7/25 document updated Corporate Quality Team recommendations for dyslipidemia screening in children, dental education, gonorrhea screening, iron deficiency anemia screening, screening for hearing loss and tuberculosis testing. These guidelines are	Full	Quarterly reports state the purpose of QMAC subcommittee meetings is to interact with members and get their feedback on topics such as quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that	



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	<p>relevant to plan Medicaid membership. QM/UM Committee minutes include discussion of clinical guidelines such as ADHD, which are based on members' needs. Disease Management programs, which have associated guidelines, were prioritized according to prevalence of conditions among plan membership.</p>		<p>may affect the Plan.</p> <p>These meetings were held quarterly in four regions. A total of 16 meetings were scheduled for 2013. Representatives from community organizations are present at the meetings to advocate for the needs of members. The EQIC reviewed QMAC reports bi-annually.</p> <p>As per QMAC meeting minutes, there is an exchange of information between the community advocates and the plan about health tips, promotional activities and community events. Also included in the meeting minutes is discussion of concerns about cultural norms and small numbers of providers affecting access to dental care.</p> <p>The 2012 Annual Evaluation described results of population analysis. This analysis performs a breakdown of member demographics, top 25 diagnoses, special needs categories, linguistic assistance, and cultural competencies. Customer service is also analyzed to direct improvements. In 2013, the plan performed the CAHPS</p>	



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			survey to assess member satisfaction. The results were used to identify opportunities of improvement according to the CAPHs report and review by EQIC and the Service Advisory Committee (SAC). As per quarterly reports, the SAC oversees evaluation and improvement efforts related to member and provider satisfaction, access, availability, and quality of service.	
developed or adopted in consultation with contracting health professionals, and	Full - The QI Program Strategy indicates that the QM/UM committee, which includes contracting health professionals, will review guidelines. The QM/UM meeting minutes include discussion clinical guidelines. Preventive health guidelines were approved by EQIC prior to the initial QM/UM meeting. MHNnet reviews behavioral Health guidelines prior to EQIC approval.	Full	The QI Program Description indicates that the QM/UM committee, which includes contracting health professionals, will review guidelines.  The QM/UM meeting minutes include discussion of clinical guidelines. Preventive health guidelines were approved by QM/UM as per report 7/30/13. MHNnet reviews behavioral Health guidelines prior to EQIC approval.	
reviewed and updated periodically.	Substantial - Committee minutes of the EQIC note that clinical practice guidelines are reviewed and updated annually by corporate Quality; local plan policy on guidelines review and adoption was not provided. The QM/UM minutes note that disease management guidelines are updated annually. EQIC minutes of 7/25 and 8/29 note updated preventive guideline	Substantial	The Work Plan indicates that clinical guidelines are reviewed, updated, and approved annually. The case management and health services teams are primarily responsible. The guidelines are also submitted to the	As a part of the CoventryCares and Aetna migration, CCKY will adopt the Aetna policy and procedures outlining development, adoption and dissemination of clinical practice guidelines.



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	<p>recommendations and immunization schedules.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The plan should consider policies/procedures regarding development, adoption, dissemination and updating of clinical practice guidelines.</p>		<p>QMUM committee for annual review according to QMUM meeting minutes listed in report 130730.</p> <p>In the prior review, IPRO recommended that CCKY consider policies/procedures regarding development, adoption, dissemination and updating of clinical practice guidelines. As noted previously, CCKY is in the process of integrating into Aetna.</p>	
<p>Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.</p>	<p>Full - The plan employs InterQual guidelines and other scientifically based guidelines from national medical research, professional medical specialty organizations or governmental agencies for UM decision making as per the QI Program Strategy, QI Program Evaluation and Provider Manual. National guidelines are also employed for disease management, which includes member education, as per QM/UM 9/20/12 minutes.</p>	<p>Full</p>	<p>The UM Program Description states that the UM program includes processes to ensure that approved clinical practices national guidelines such as InterQual are applied equitably throughout the plan's provider network. UM evaluates medical necessity based upon evidence based medical guidelines and assures that providers are educated on current clinical criteria. The QMUM Committee reviews and approves clinical practice guidelines, preventive health guidelines, and the disease management program.</p> <p>The disease management guides reflect educational outreach to</p>	



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			<p>members including mailings, telephonic outreach, access to community resources, and web-based education.</p> <p>The provider manual indicates that medical necessity determinations are made based on McKesson's InterQual® criteria, which is a nationally-recognized evidenced-based product. Copies of criteria used in making medical necessity determinations may be obtained online at <a href="http://www.directprovider.com">www.directprovider.com</a>, by phone or by requesting a hard copy. A Medical Director is available for peer-to-peer discussions.</p> <p>The Member Handbook discusses the UM program.</p>	
<b>19.5 Innovative Programs</b>				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.	<p>Minimal - The plan provided information on its Text 4 Baby program. The plan also provided text describing lower levels of behavioral health care including Intensive Outpatient Programming (IOP) and Partial Hospitalization (PHP) to allow members to transition to outpatient care or avoid hospitalization.</p> <p>Reports on the plan's program to improve and reform the pharmacy program management were not provided for review.</p>	Full	As per the QI Program Description, CCKY's Pharmacy Benefit Manager where applicable, uses a Drug Utilization Review (DUR) program, in conjunction with retail pharmacy computer systems, alerts pharmacies of potential drug to drug interactions and adverse effects resulting from the	



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	<p>The plan provided text that use of generic drugs is promoted in the plan's formulary, and has successfully increased generic drug dispensing rates.</p> <p><b>MCO Response:</b> CoventryCares of Kentucky has a Policy (PHM – 002) that provides criteria for the formulary. One of the criterion for a drug to be added – as long as safety and efficacy are comparable – is cost. Drugs that have lost patent protection and are available as generics will be selected under this criteria. Kentucky Pharmacy Law and claims processing logic mandates that the lowest cost generic be dispensed when a prescription is written for a product that has lost patent protection. These elements combine to drive market share to generics.</p> <p>As proof of the efficacy, market share – as shown in the Pharmacy Monthly Dashboard – for CoventryCares of Kentucky grew from 81.5% in March, 2012 to 86.4% in March, 2013.</p>		<p>age or gender of a member; or other pharmacy problems at the time a prescription is filled.</p> <p>Additionally, CCKY maintains a local pharmacy and therapeutics (P&amp;T) committee which is responsible for advising the National P &amp; T Committees regarding local and community needs related to the health plan's pharmacy benefit program(s). The Kentucky P&amp;T Committee is a sub-committee of the EQIC that ensures members receive the maximum value from their pharmacy benefit by continual reinforcement of high quality, cost-effective prescribing habits of CCKY practitioners.</p> <p>Meeting minutes indicate that the QMUM committee reviewed a Chronic Opiate Policy and the Fraud/Waste/Abuse report on Narcotics. A document entitled the "CoventryCares of Kentucky Prior Authorization for Schedule II, III and IV Opiate Containing Medications" was distributed by Medco, the plan's pharmacy vendor, to inform providers of changes to prior authorization</p>	



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			<p>requirements for short-acting and long-acting opiates.</p> <p>Regarding CCKY's program to improve and reform the pharmacy program, CCKY provided a spreadsheet containing monthly data for Suboxone versus generic dispensing. The rates dropped from 97.97% Suboxone/2.03% generic in April 2012 to 0.78% Suboxone/99.22% generic as of January 2013.</p> <p>During the onsite interview, CCKY indicated that this was achieved via use of co-pay tiers, formulary changes, and physician education and that in general, use of generics had increased to ~ 89 – 90%.</p> <p>In 2013, IPRO noted that reports on the plan's program to improve and reform the pharmacy program management were not provided for review. For the current review, CCKY provided more complete information, as described above.</p>	
<b>20.1 Kentucky Outcomes Measures and HEDIS Measures</b>				



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<p>The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix O, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.</p>	<p>Full - The plan has not yet reported Kentucky outcomes or HEDIS measures. However, the plan has begun activities targeted to these measures as reported in quarterly reports 18 and 17. The plan has also begun monthly monitoring of HEDIS measures and implemented a work group for HEDIS reporting. The QI Work Plan includes Healthy Kentuckian performance measures Adult and Child BMI and counseling, cholesterol screening, adolescent screening, prenatal risk assessment and CSHCN as well. EQIC minutes of 6/13/12 indicate that seven measures have been targeted for interventions for improvement, including "childcare" visits, cervical cancer screening, BMI, and prenatal/postpartum. These targeted measures are further discussed in EQIC 8/29 minutes, where it is noted that EPSDT reminders will address well visits, and that 20 providers contributing to these measures will be targeted for intervention. The QI Work Plan also includes monitoring of the HEDIS measures controlling high blood pressure, annual dental visit, well child visits, lead screening and access to PCPs as per "HEDIS timeframes". MNet is working with PCPs regarding Antidepressant Medication Management. Non-compliant members are being identified for HEDIS measures, and members who are missing services are being identified for providers.</p>	<p>Full</p>	<p>In 2013, CCKY reported its first Healthy Kentuckians Outcomes performance measure rates. The QI Work Plan lists as objectives improving rates on the following indicators: BMI; Nutritional Screening/Counseling; Physical Activity Counseling; Height and Weight for children and adolescents; Cholesterol Screening for Adults; Adolescent Screening/Counseling; Prenatal Risk Assessment Counseling and Education; Children with Special Health Care Needs (CSHCN) (access and preventive care).</p> <p>In 2013, CCKY reported its first HEDIS measure rates. CCKY's HEDIS 2013 Results and Goals indicates that the following measures met the 10<sup>th</sup> percentile: Comprehensive Diabetes Care - Eye Exam; Controlling High Blood Pressure; Use of Imaging Studies for Low Back Pain; Weight Assessment Counseling – BMI, Nutrition, &amp; Physical Activity; and Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.</p> <p>The QI Evaluation relates that CCKY has posted gap reports to the provider</p>	



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			portal (directprovider.com); worked collaboratively with MHNet on an initiative to address substance use in pregnancy; sent reminders for post partum visits; and addressed EPSDT services by hiring an EPSDT Case Manager, conducting outreach, sending reminders; working with high volume pediatric practices; and addressing members' transportation problems.	
Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	NA - measures not yet reported	Not Applicable	CCKY reported its first HEDIS data in 2013. On annual basis DMS in collaboration with the EQRO, evaluates the measures required for reporting. The measure set has been revised and refined. MCOs are encouraged to provide input and have done so. To date, no measures have been rotated.	
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	NA - the plan was provided with specifications for Individuals with Special Health Care Needs (Children and Adolescents) Access and Preventive Care, but has not yet reported on this measure, provided feedback or worked collaboratively as of yet on measure development.	Full	The ISHCN measures were selected prior to CCKY's participation in Kentucky Medicaid. However, CCKY reported the Healthy Kentuckian Outcomes performance measures for the first time in 2013 as required.	
The Department shall assess the Contractor's achievement of performance improvement related to	NA - the plan has not yet reported the health outcome measures.	Full	CCKY reported the Healthy Kentuckian Outcomes performance measures for the first time in 2013 as required.	



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the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.			Improvement initiatives are in progress. However, Remeasurement to assess improvement will not occur until 2014.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.	NA - While the workgroup has not yet set performance targets and goals, the QI Work Plan includes a category related to Kentucky performance measures Adult and Child BMI and counseling; cholesterol screening, adolescent screening, prenatal risk assessment and CSHCN. Quarterly report 18 is specific to activities regarding performance measures and report 17 is specific to Work Plan activities updates; these reports were submitted for 2012 on 4/30/12, 7/30/12 and 1/30/13. An annual report of performance measure data and demographic stratification was not yet available for review, as they will be reported in 2013.	Full	<p>The Healthy Kentuckians Outcomes measures include performance targets/goals.</p> <p>The QI Program Description addresses both the Kentucky Appendix O measures and HEDIS measures.</p> <p>The QI Work Plan includes monitoring of indicator benchmarks and outcomes; quarterly reporting of QI initiatives; and lists each of the Appendix O performance measures as a task for improvement efforts.</p> <p>An annual report of performance measure data and demographic stratification will be reported in the 2013 QI Evaluation (pending committee approval). CCKY did submit its HEDIS data stratified with the final audit report and IDSS.</p>	
<b>20.2 HEDIS Performance Measures</b>				
The Contractor shall be required to collect and report HEDIS data annually.	NA - The plan is scheduled to report HEDIS measures for the first time in 2013. The plan indicated during the onsite meeting that	Full	CCKY reported its first HEDIS data in 2013 and will report HEDIS 2014 in	



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<p>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>.</p>	<p>monthly administrative HEDIS rates were currently being run and tracked; reports were not provided for review. Preparations for HEDIS reporting include HEDIS meetings and engagement of other plan departments. August 29 EQIC minutes note that the plan is developing a HEDIS culture, with participation of all departments in HEDIS.</p> <p>There is a corporate HEDIS team in place, and the plan staff can access the Navigator system to build on provider HEDIS information. As per the QI Work Plan, HEDIS activities are scheduled for 2013, including a HEDIS audit and reporting.</p>		<p>June 2104. The data was audited and CCKY provided the final audit report, IDSS, and stratified measure rates as required.</p>	
<p>In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.</p>	<p>NA - measures not yet reported.</p>	<p>Full</p>	<p>CCKY submitted the final audit report, IDSS, and table of HEDIS 2013 rates with percentile ranking and national average and 75<sup>th</sup> percentile for comparison.</p> <p>No trending was possible, as this is the first reporting year.</p> <p>Denominators, numerators, and rates are included in the IDSS.</p> <p>A "HEDIS 2014" report was submitted and included CCKY's HEDIS 2013 results and goals for HEDIS 2014. According to CCKY, HEDIS 2014 goals were chosen using NCQA's HEDIS Benchmark and Goal Setting Methodology.</p>	



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For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	NA - measures not yet reported.	Full	CCKY included the stratified Effectiveness of Care (EOC) and Access/Availability (A/A) measure rates in 2 embedded files within the HEDIS report document submitted.	
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.	NA - measures not yet reported.	Not Applicable	HEDIS 2013 (Measurement Year 2012) was the first year for reporting at the CCKY.  To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	NA - measures not yet reported.	Not Applicable	HEDIS 2013 (Measurement Year 2012) was the first year for reporting by CCKY.  To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	
<b>20.3 Accreditation of Contractor by</b>				



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<b>National Accrediting Body</b>				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.	NA - the plan has not yet undergone the NCQA accreditation process or audit. NCQA accreditation is planned for 2014.	Not Applicable	NCQA accreditation is planned for July 2014. Preparation for the accreditation survey is in progress as seen in the EQIC, QMUM, and QMAC meeting minutes and the QI Work Plan.	
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.	NA - The plan is preparing for NCQA accreditation, and the QI Work Plan notes an anticipated NCQA accreditation as of 2014.	Not Applicable	CCKY is currently pursuing accreditation.	
<b>20.4 Performance Improvement Projects (PIPs)</b>				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily	Full - The two topics that were submitted 9/1/12 were not accepted by DMS due to lack of focus. The plan ultimately chose Major Depression and ED Utilization as PIP topics. The re-	Full	The 2013 PIPs address topics that are issues of state and national concern and areas where CCKY did not meet	



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<p>measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed.</p>	<p>submitted PIP proposals address the relevance of the topics to the plan membership very well, and the topics are challenging to address and were approved by DMS/EQRO. Major Depression is prevalent, and ED utilization is a noted problem area for the plan that may indicate access problems. The plan considered potential disparities in care in the proposal. The PIP topics were approved by the EQIC and the QM/UM committees.</p>		<p>national benchmarks: Major Depression and ED Utilization.</p> <p>The 2014 PIP topics include Preventing Readmissions and ADHD.</p> <p>CCKY's PIP proposals included strong rationales, with current performance, relevance to the plan membership, potential disparities.</p> <p>The PIP topics were approved by the EQIC and the QM/UM committees, and ultimately, by DMS and the EQRO, IPRO.</p>	
<p>The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be</p>	<p>Full - The plan's P/P QI-005 outlines the process for PIPs, including types of projects (clinical and non-clinical), prioritizing topics to address specific needs of members and subsequent to population analysis, interventions, and monitoring status. The plan monitors quality and appropriateness of care and services through performance measures, surveys and medical record audits as described above and in P/P QI-005. Other than the two PIP topics described above, which are based on some monitoring of plan performance with regard to antidepressant adherence and ED utilization, there were no specific PIPs undertaken. Interventions include member and provider education and case management. Payment to providers was not part of planned interventions. The plan is addressing the entire plan membership and the subpopulation of members with depression, and is planning to evaluate potential disparities in care among</p>	<p>Full</p>	<p>P/P QI-005 outlines the process for PIPs, including types of projects (clinical and non-clinical), prioritizing topics to address specific needs of members and subsequent to population analysis, interventions, and monitoring status was provided onsite.</p> <p>The PIP topics were based on some monitoring of plan performance with regard to antidepressant adherence, ED utilization, care for ADHD and rates of hospital readmissions. The PIPs each address clinical topics, with one for PH and one for BH for each year, as</p>	



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<p>made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to members and providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.</p>	<p>subgroups of members with depression.</p>		<p>required. The PIP topics were approved by DMS and the EQRO, IPRO.</p> <p>No non-clinical/service PIPs have been proposed, though CCKY has addressed service improvements for internal purposes.</p> <p>To date, no additional PIPs have been required of CCKY by DMS. However, CCKY has participated in EQRO focus studies related to postpartum and newborn readmissions and EPSDT services.</p>	
<p>The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public</p>	<p>Full - This is included in P/P QI-005. As reported in the second quarter's MCO reports, the plan's case managers collaborate with local health departments, school based health centers and community health care resources in coordinating care. These reports also note that case management staff collaborates with the Department for Child Based Services (DCBS) by presenting care plans if there are newly identified health problems and</p>	<p>Full</p>	<p>Collaborative relationships are addressed in P/P QI-005, which was provided onsite. During the onsite interviews, CCKY described collaboration with local Departments of Public Health noting that it works with 196 LHDs in the 120 counties it</p>	



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health agencies is an essential element for the achievement of public health objectives.	communicating with the state's regional case workers. Case Management also refers to the Commission for Children with Special Health Care Needs as applicable. Quarterly reports also note that the plan uses community resources such as shelters for outreach to the homeless population. The plan's Community Outreach Coordinators serve on homeless coalitions as well. As reported by onsite staff, MHNet is partnering with community mental health centers.		serves, via local outreach staff.  Initiatives include: substance abuse in pregnancy; community events such as baby showers and diabetes education; biweekly meetings to collaborate on provider relations and coverage issues.  CCKY worked to address LHD concerns regarding Norton Health System participation in its network.	
The Department and the Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data-driven performance measures.	Full - The plan provided documents and staff for the October onsite meeting and compliance review, and has been responsive to DMS comments regarding PIPs. The plan is using State-provided historical encounter data to identify high risk members.	Full	The QI Program Description states that CCKY will cooperate with DMS and the EQRO on improvements in services and clinical care concerns.  CCKY has participated in EQRO focused studies and fulfilled QI contract requirements, including conducting PIPs, reporting performance measures and HEDIS, participating in EQRO focused studies, and submitting documentation and data for the annual review.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to	Full - The plan submitted two PIP proposals that are relevant to the plan's population and evaluation of plan data as noted in the rationale. PIPs address both behavioral health and physical health. The topics include Major Depression and ED Utilization. The annual statewide PIP has not yet been conducted, and not	Full	As described previously, CCKY has two 2013 PIPs in progress and submitted proposals for two 2014 PIPs. The PIPs address behavioral health and physical health needs. PIP reports have been	



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<p>behavioral health. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department may require Contractor to (i) implement an additional PIP specific to the Contractor; if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.</p>	<p>other PIPs have yet been required.</p>		<p>submitted as required.</p> <p>CCKY has not submitted an alternate PIP topic. DMS has not required CCKY to implement an additional PIP.</p> <p>DMS has not yet required CCKY to participate in a state-wide PIP, but MCOs have assisted with EQRO focused studies by providing requested data and documentation.</p>	
<p>The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix N.</p>	<p>Full - The plan initially identified topics for each of the four areas identified by the Department; after clarification, the plan submitted two proposals, one addressing Major Depression and the other ED Utilization, which were approved by the Department.</p>	<p>Full</p>	<p>CCKY initially proposed topics for each of the four areas identified by DMS. After clarification, CCKY submitted two proposals for 2013 PIPs: Major Depression and ED Utilization. These topics were approved by DMS. CCKY also submitted proposals for two 2014 PIPs: Hospital Readmissions and</p>	



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			ADHD. Those topics were approved by DMS as well.	
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:	Full - The plan submitted their PIP proposals on the template provided by the Department, and the proposals were approved. P/P QI -005 includes the elements below.	Full	CCKY submitted the PIP proposals on the template specified by DMS. The proposal topics were approved.  P/P QI -005 addresses the elements below and was provided onsite.	
A. Topic and its importance to enrolled members;	Full - Topic relevance was well described in each revised PIP.	Full	Topic relevance was well described in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
B. Methodology for topic selection;	Full - Rationale for the topic selection included statewide and plan-specific data to justify topic selection in each revised PIP.	Full	Rationale for the topic selection included statewide and plan-specific data to justify topic selection for each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
C. Goals;	Full - Rationale for the topic selection included statewide and plan-specific data to justify topic selection in each revised PIP.	Full	Goals/targets for improvement are included in each of the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
D. Data sources/collection;	Full - Data sources and collection procedures were described for each revised PIP.	Full	Data sources and collection procedures were described in each of	



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			the four PIP proposals. CCKY revised the proposals based on EQRO recommendations.	
E. Intervention(s) – not required for projects to establish baseline; and	Full - Interventions were described for each PIP initially that were somewhat passive and generic. Subsequent revisions included updated interventions that were active and targeted to the topic.	Full	Active and targeted interventions were described in each of the four PIP proposals though there were relatively passive interventions in some cases. CCKY revised the proposals based on EQRO recommendations.	
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.	NA - Results are not yet available for the PIPs.	Substantial	<p>Baseline results for the 2013 PIPs were submitted, but in some cases, were not clear, requiring clarification. CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports.</p> <p>A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs.</p> <p><b><u>Recommendation for CCKY</u></b> Baseline results should be clearly presented in the PIP reports.</p>	<p>CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports.</p> <p>A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs.</p> <p>Baseline measurements completed for reports in 2014 will follow the recommendations for clearly comparing results to our goals.</p>
The final report shall also answer the following questions and provide				



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information on:				
A. Was Member confidentiality protected;	NA - proposal only submitted. This is included in P/P QI-005.	Full	The four PIP proposals address member confidentiality.	
B. Did Members participate in the performance improvement project?	NA - proposal only submitted. However, members are targeted for interventions in both PIPs.	Not Applicable	PIPs are still in process; however, member interventions are addressed in all PIPs.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	NA - proposal only submitted.	Not Applicable	PIPs are not yet completed.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;	NA - proposal only submitted.	Not Applicable	PIPs are not yet completed.	
E. Is there an executive summary;	NA - proposal only submitted.	Not Applicable	PIPs are not yet completed.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	NA - proposal only submitted.	Substantial	As indicated previously, the baseline results for the 2013 PIPs were sometimes not clear, requiring clarification. CCKY followed the EQRO recommendations and was able to more clearly present the results.  <b><u>Recommendation for CCKY</u></b> Baseline results should be clearly presented in the PIP reports.	CCKY followed the EQRO recommendations and was able to more clearly present the results. Plans for continuing interventions were presented in the PIP reports.  A comparison to goals is not yet relevant as CCKY has only completed baseline measurements for its 2013 PIPs.  Baseline measurements completed for



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				reports in 2014 will follow the recommendations for clearly comparing results to our goals.
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be predetermined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement	Full - The plan identified appropriate indicators based on HEDIS measures for the two PIP proposals that were submitted; goals were established and benchmarks from national data were identified in the rationales. Other relevant indicators, such as Medication Possession Ratio for adherence, are also included in the proposals.	Substantial	CCKY used HEDIS measures for indicators where available and also selected Medication Possession Ratio for the MDD PIP. However, in some cases, CCKY's methodology for use of the measures was not clear. CCKY was able to clarify the indicators with EQRO assistance.  For HEDIS measures, the goals were based on benchmarks from national data.  <b>Recommendation for CCKY</b> PIP methodology should be clearly presented in the PIP reports.	CCKY followed the EQRO recommendations and was able to more clearly define the methodology.  PIP methodology for reports in 2014 will follow the recommendations for clear presentation.
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	NA - proposal only submitted.	Not Applicable	NA – the 2013 PIPs are in the baseline/interim phase and the 2014 PIPs are in the proposal stage.	
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of	Full - The original proposals were submitted to DMS on September 1, 2012.	Full	The initial 2013 and 2014 PIP proposals were submitted on or before September 1 <sup>st</sup> of the respective year	



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Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.			(2012 or 2013).	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	NA - proposal only submitted.	Full	The 2013 PIP baseline reports were submitted August 31, 2013.	
C. 1 <sup>st</sup> Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	NA - proposal only submitted.	Not Applicable	The 2013 PIPs are currently in the first year. The 2014 PIPs are in the proposal/baseline measurement phase.	
D. 2 <sup>nd</sup> Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	NA - proposal only submitted.	Not Applicable	The 2013 PIPs are currently in the first year. The 2014 PIPs are in the proposal/baseline measurement phase.	
<b>20.5 Quality and Member Access Committee</b>				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Full - The plan has established a Quality and Member Access Committee as a subcommittee of the EQIC. The committee's membership includes members and consumer advocates. There are regional quarterly meetings of the QMAC. Onsite staff referenced a member advisory committee that meets at least twice a year; and acts as an ad hoc focus group.  The plan provided QMAC minutes from 2/25/12, 9/12/12 and	Full	The plan has established a Quality and Member Access Committee as a subcommittee of the EQIC. The committee's membership includes members and consumer advocates. There are regional quarterly meetings of the QMAC. The plan submitted QMAC meeting minutes.	



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	12/19/12. The plan provided membership lists that include members, individuals from advocacy groups and community groups.		Membership lists reveal a variety of community interests represented.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Responsibilities of the Committee shall include:	Full - As per the QMAC Committee Description, membership will be consistent with plan population with regard to these factors. Meetings are held at different regional locations to facilitate regional representation. Membership lists reveal a variety of communities represented.	Full	Consistent with the Committee Description, the quarterly reports indicate that the QMAC sub-committee meets quarterly and the committee is comprised of members and consumer advocates who represent the interests of members. The QMAC meetings are held in four regional groups: South-West (Regions 1, 2 & 4), North Central (Region 31), North East (Regions 5 & 6), and East (Regions 7 & 8) so that members from across the state are represented.	
A. Providing review and comment on quality and access standards;	Full - This is included in the QMAC Committee Description. The role of the QMAC is to give feedback on topics such as marketing materials, customer service network access, benefit information and the health plan overall. QMAC minutes reveal review of the plan's provider directory, provider network status, and overview of QI, HEDIS measures and EPSDT standards.	Full	According to the Committee Description, the purpose of the committee is to interact with members and get feedback on quality of care, marketing materials, customer service, network access, benefit interpretation, and other areas that may affect the plan.  QMAC meeting minutes include discussion and review of the QI Program Description and the QI Work Plan and review of the Provider	



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			Directory, overview of QI, HEDIS measures and EPSDT standards.	
<p>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;</p>	<p>Minimal - This is included in the QMAC Committee Description. Evidence of QMAC review and comment on grievance and appeals policy and process was not available for review.</p> <p><b>MCO Response:</b> As part of CoventryCares' quarterly Executive Improvement Committee (EQIC) meetings, the Appeals Department submits Quarterly Appeals and Grievance reports. These reports reflect the totals, trends, and key indicators in the data that are necessary to track the success of the department and the compliance with state/federal regulations. The Appeals Manager is responsible for presenting an overview and analysis of the data which is heard by the EQIC committee, and feedback is offered as needed.</p> <p>Please refer to attached policies, procedures, reports and minutes. Please note, the appeals and grievances reports with discussion are reflected in the EQIC minutes, not the Quality Member Access Committee (QMAC) minutes as identified in the EQRO report. Please refer to the attached EQIC minutes that reflect the reports, discussion, and follow-up. Please note, the follow-up action noted at the November 2012 meeting was reported at the February 2013 meeting (enclosed).</p> <p>Actions for improvement based on the findings and analysis of the 2012 grievances include; weekly CSO calls to discuss issues for how complaints are loaded and handled in the data system, and established action plans for necessary improvements and education; education to the grievance team on how to code</p>	Full	<p>The quarterly report 131030 contains QMAC minutes discussing the Appeals and Quality of Care Grievances processes.</p> <p>During the onsite interview, CCKY indicated that during the first committee year (2012) the QMAC was a statewide committee that involved too much travel for participants. CCKY changed to the regional model as described above. There are outreach coordinators in the four regions who recruit members and advocates including CSHCN advocates and coordinate meetings and communication.</p> <p>In Q4 2013, the QMAC reviewed the Member Handbook and member educational materials.</p>	



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	<p>issues appropriately; report on a quarterly basis numbers and types of grievances, along with analysis to outline key areas for improvement; work with provider relations to educate providers, and contract with those out of network when possible; work with the QI department for best practices in coding grievances correctly; establish a new electronic filing system for grievances so that we can ensure better compliance with letters and documentation; new processes designed to verify that correct letters have gone out, the correct department is resolving issues, and that resolution letters are sent out on all complaints; implement a new Quality Check tool for Grievances (verifies that we are compliant with all guidelines set forth by the Commonwealth of Kentucky and other regulatory bodies); update our data reports to more accurately measure timeframes and to identify complaints consistent with the definition in our policies and procedures.</p> <p><b>IPRO Comments:</b> No change in review determination. It is noted in Section 19.4 that the plan monitors grievances and appeals. This contract requirement (20.5B) refers to review and comment on the grievance and appeal process by the QMAC.</p>			
C. Review and provide comment on Member Handbooks;	Full - This is included in the QMAC Committee Description. QMAC minutes of 12/19/12 include evidence of QMAC review and comment on Member Handbooks.	Full	The QMAC bi-annual report to EQIC includes evidence of QMAC review and comment on the Member Handbook.	
D. Reviewing Member education materials prepared by the Contractor;	Full - This is included in the QMAC Committee Description. QMAC minutes of 12/19/12 include member feedback on the plan's website. The QMAC discussed educational materials on 4/25 and the requirement for translation and sixth grade reading level.	Full	Quarterly report 130430 includes QMAC review of the Member Handbook, member educational materials, the Provider Directory, and the CCKY website.	



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E. Recommending community outreach activities; and	Full - This is included in the QMAC Committee Description. Community activities and the role of Community Outreach Coordinators were discussed on 4/25/12.	Full	Quarterly reports describe QMAC review of CCKY's community outreach activities such as the Baby Crib Program, Teen Mom Program and Smoking Cessation Program. The meeting minutes indicate that community advocates who were present at the meeting were encouraged to share their upcoming events	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - This is included in the QMAC Committee Description. The QMAC minutes reveal review of member surveys and PIPs, Enhanced Case Management, Provider Representatives, and translation and interpreter services.	Full	QMAC minutes reveal review of EPSDT and lead screening programs, the Quality of Care process, review of PIPs and member handbook, provider directory and formulary. As noted previously, the QMAC reviewed the P/P for grievances and appeals.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - The plan submitted a list of participating members in the second quarterly MCO reports. The plan submitted membership lists for April 2012, September 2012 and December 2012.	Full	CCKY submitted a list of QMAC members in the Q1 2014 Quarterly Report (reporting period 10/2013 – 12/2013). The member list reveals a variety of community interests represented.	
<b>20.8 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	Full - The Provider Satisfaction survey was conducted in 2012, and a report was provided. As per onsite staff and as reflected in the EQIC minutes and quarterly reports, the plan implemented a	Full	The plan conducted the CAHPS survey in 2013 and the Provider Satisfaction Survey in 2012 and 2013.	



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provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Transactional Survey initiated by CSO representatives, who send a web link to the provider, and a modified version (Health Plan Survey) sent to providers via fax blast. A planned member survey (CAHPS) is documented in the QI Work Plan for 2013.			
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - The QI Work Plan includes providing a copy of the CAHPS survey tool to NCQA and the EQIC in 2013; the plan indicated that all documents were approved by the Department in January 2013.	Full	The QI Work Plan includes administration and analysis of the CAHPS survey. The QI Work Plan indicates that the results were reported to SAC committee in September 2013. DSS is CCKY's survey vendor. The survey was submitted to DMS.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	Substantial - The plan has not yet conducted special member surveys, although surveys of members regarding Health Services are referenced in the UM Program Description. Onsite staff indicated that a behavioral health member survey had been conducted.  <b>Recommendation for Coventry Cares</b> The plan should ensure that the need for special surveys that target subpopulations perspective and experience is assessed.	Full	CCKY reported that CM Satisfaction surveys are administered and that a POS type Customer Service Survey for both members and providers is being considered.  The EQRO, IPRO, will be conducting a BH-focused survey.	
To meet the provider satisfaction survey	Full - The QI Work Plan indicates that the 2012 provider survey	Full	As per the Work Plan, the 2013	



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requirement the Contractor shall submit to the Department for review and approval the Contractor's current provider satisfaction survey tool.	tool was submitted to DMS on July 30, 2012. The plan provided a report of the survey that included survey items.		Provider Satisfaction Survey was scheduled in the third quarter.  The tool and report were submitted to DMS.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	Full - The plan provided a copy of the Provider Satisfaction Survey report; this report included methodology, response rates, and survey items. Member survey documents were approved by the Department in January 2013 as per the plan.	Full	The plan provided a copy of the Provider Satisfaction Survey report and the CAHPS survey results; these reports included methodology, response rates, and survey items.	
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - The Provider Satisfaction Survey report was provided by the plan. At the time of review, the member survey has not yet been conducted. There was no documentation of a request for survey results by members.	Full	CCKY submitted the Provider Satisfaction Survey report and included this in the pre-site documentation.	
<b>37.5 QAPI Reporting Requirements</b> The Contractor shall provide status reports of the QAPI program and work	Full - As per the QI Program Strategy, quarterly status reports will be provided to the Department. Quarterly status reports, including an updated QI Work Plan, Quality Activity Summary,	Full	The QI Program Description reports that the plan will make available to state Medicaid agencies as	



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plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Indicator Monitoring, PIP status, Committee Activity, activities addressing EPSDT and pregnant women, and other required reports were submitted to DMS for 2012.		contractually required and upon request all data, clinical and other records/reports for review of quality of care, access and utilization issues including, but not limited to, activities related to External Quality Review (EQR), HEDIS®, encounter data validation, and other related activities. CCKY submits Quarterly Status Reports to DMS are required.	
Reference the following documents for further information: Appendix K Appendix N Appendix O				



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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	81	9	0	0
Total Points	243	18	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>2.9</b>		

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

**Reviewer Decision:**

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

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

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



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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, membership, meeting agendas and minutes

Committee description, membership, meeting agendas and minutes for QMAC

Clinical Practice Guidelines

Provider Manual

Provider Newsletters

Provider Committee minutes

Innovative Program description and status report

#### **Reports**

Annual QI Evaluation Report

HEDIS Final Audit Report and IDSS rates

Healthy Kentuckians Outcomes Measures Report

CAHPS Report

Provider Satisfaction Survey Report

NCQA Accreditation Certificate and ISS Survey Report or status of accreditation

Performance Measure Reporting

Evaluation, analysis and follow-up of performance measure results

Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines

Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of services



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**Grievance System**  
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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>24. General Requirements for Grievances and Appeals</b>				
The Contractor shall have a grievance system in place for Members that includes a grievance process related to "dissatisfaction" and an appeals process related to a Contractor "action," including the opportunity to request a State fair hearing pursuant to KRS Chapter 13B.				
The Contractor shall implement written policies and procedures describing how the Member may submit a request for a grievance or an appeal with the Contractor or submit a request for a state fair hearing with the State. The policy shall include a description of how the Contractor resolves the grievance or appeal.				
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf.	Substantial - As per P/P APP-003, providers may contact the Appeals Department of Customer Service to file a grievance or appeal; providers who contact Customer Services will be educated regarding how to file an appeal and assisted as necessary. The process for provider grievances and appeals is also outlined in the Provider Manual. The Provider Manual describes the process for filing an appeal on a member's behalf, but does not appear to address filing a grievance on a member's behalf. The Member Handbook does indicate that a provider can file a grievance on a member's behalf with written consent. P/P APP-003 indicates a provider may file	Substantial	Provider Manual; Section 10 Complaint Process for Provider and Members describes the process for a provider to file an appeal on the member's behalf however, but does not include that a provider may file a grievance on a member's behalf or the process. P/P APP-002, 003, 004, 006, indicate that a grievance may be filed either orally or in writing within 30 days of the event, and that a member, representative or service provider have the right to file a grievance on behalf of the member.  <b><u>Recommendation for CCKY</u></b> As noted in the prior review, CCKY	CoventryCares of Kentucky will updated the Provider Manual to include the process for filing a grievance on a member's behalf in the Fall 2014 Provider Manual.



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	<p>an appeal on member's behalf.</p> <p><b><u>Recommendation for Coventry Cares</u></b>            The plan should include the process for filing a grievance on a member's behalf in the Provider Manual.</p>		<p>should include the process for filing a grievance on a member's behalf in the Provider Manual.</p>	
<p>The Contractor shall make available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.</p>				
<p>The Contractor shall name a specific individual(s) designated as the Contractor's Medicaid Member grievances or appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.</p>	<p>Substantial - P/P APP-004 identifies the Quality Department as responsible for quality of care concerns, Provider Services for quality of service concerns and all other grievances are the responsibility of the Appeals and Grievances departments.</p> <p>P/Ps APP-004 and APP-002 identify the Appeals Coordinator in the Appeals and Grievances Department as responsible for member notifications and preparing the file for review by the appeals committee; the Appeals Coordinator is also responsible for grievances related to benefits, claims or services and for member notification regarding decisions</p>	Full	<p>P/P APP-004 Members Grievance, APP-002 Appeals-Members addresses the designated individual for member grievances and appeals.</p> <p>In the prior review, IPRO noted that CCKY should clarify roles and ensure coordination of staff so that categorizations are appropriate and consistent, and complete member notification and resolution occurs. The current file review results demonstrate that the recommendations from the prior review have been addressed. A new system and process was implemented.</p>	



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	<p>for these grievances as well as quality of service grievances. The Customer Service representative is identified as responsible for identifying to which category a grievance belongs, and also for determining whether a dispute is eligible for an appeal and informing the member of timeframes if Customer Service receives the call as per APP-002. As noted above, Customer Service representatives also identify if a complaint is a quality of care concern or quality of service concern. Quality of service concerns are tasked to Provider Relations as per APP-004, and as per P/P QI-014, potential quality of care concerns are entered into the plan's Navigator system and are forwarded to the QI Department.</p> <p>P/P APP-004 indicates that management staff meets every week to review grievances to ensure appropriate triage and categorization and summarize trends. Findings are reported to the Executive Quality Improvement Committee (EQIC) to evaluate, track and trend the root cause of dissatisfaction. Trending of appeals does not appear specifically addressed in appeals policies, though included in Quality Improvement</p>			



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	<p>and UM documents.</p> <p><b><u>Recommendation for Coventry Cares</u></b>            With some overlap of responsibility of Customer Services and Appeals Coordinator, and some issues with member notifications and categorizations as well as lack of clear documentation of resolution in some grievances forwarded to other departments as described below, the plan should clarify roles and ensure coordination of staff so that categorizations are appropriate and consistent, and complete member notification and resolution occurs.</p>			
<p>The Contractor shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:</p>	<p>Substantial - P/Ps APP-001 and APP-002 specify that Appeals Committee members cannot be involved in prior review or decision making. This is also stated in P/P APP-005 regarding subcontractors' grievances and appeals. For one EPSDT appeal file provided on the second day of review, there was no appeal documentation in the file (no oversample for EPSDT). For all other grievances and appeals where applicable, individuals making decisions were not involved in previous review or decision making.</p>	<p>Full</p>	<p>P/P APP-002 addresses the requirement that individuals who make decisions on grievances or appeals are not involved in previous review or decision-making.</p> <p>P/P APP-001 addresses the requirement that individuals involved in the Appeal Review were not involved in the initial action and who are not the subordinate of an individuals who made the initial action decision.</p> <p><u>Appeal File Review</u>            File review results demonstrate that files</p>	



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	<p><b><u>Recommendation for Coventry Cares</u></b>            The plan should ensure that appeal files are complete and that individuals making decisions on appeals have appropriate clinical expertise.</p>		<p>were complete and reviewers were appropriate. The full sample for each file type was available.</p> <p><u>Member Appeal File Review</u>            Seven files were reviewed. 7 of 7 files were reviewed by appropriate individuals.</p> <p><u>EPSDT Appeal File Review</u>            Five files were reviewed. 5 of 5 files were reviewed by appropriate individuals.</p> <p><u>Provider Appeal File Review</u>            Ten files were reviewed. 10 of 10 files were reviewed by appropriate individuals.</p> <p><u>Member Grievance – Random File Review</u>            Ten files were reviewed. 10 of 10 files were reviewed by appropriate individuals. No grievances were related to clinical issues.</p> <p><u>Member Grievance – Quality File Review</u>            Ten files were reviewed. 10 of 10 files were reviewed by appropriate individuals.</p>	



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			<p><u>Provider Grievance File Review</u>            Five files were reviewed. 5 of 5 files were reviewed by appropriate individuals.</p> <p>In the prior review, IPRO recommended that CCKY should ensure that appeal files are complete and that individuals making decisions on appeals have appropriate clinical expertise. The current file review demonstrates that the issue was addressed.</p>	
A. An appeal of a Contractor denial that is based on lack of medical necessity;				
B. A Contractor denial that is upheld in an expedited resolution; and				
C. A grievance or appeal that involves clinical issues.	<p>Substantial - Reviews of appeals based on clinical issues are reviewed by appropriate health care professionals as documented in APP-001, APP-002 and APP-005.</p> <p>As noted above, all files documenting appeals involving clinical issues were reviewed by appropriate health care professionals.</p>	Full	<p>P/P APP-001 addresses clinical appeals reviewed by appropriate health care professionals not involved in the initial decision.</p> <p>P/P APP-002 addresses clinical appeals reviewed by appropriate health care professionals who were not involved in the initial action and who are not the subordinate of an individual who made</p>	



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	<p>As per P/P APP-004, grievances that are phoned into Customer Service are determined to be quality of care concerns, i.e. based on treatment rendered, by the Customer Service representative. Written grievances are handled by the Appeals Coordinator in the Appeals and Grievance Department. Once determined to be a quality of care concern, the grievance is forwarded to the QI Department. Examples of quality of care issues in this policy include medical mismanagement, treatment delay, failure to provide timely equipment, medication or referral, inappropriate delayed response to recommended care and unauthorized release of PHI.</p> <p>As per QI-014, quality of care concerns are reviewed by the Quality Improvement Coordinator. If the case cannot be closed by the QI Coordinator, the grievance is referred to a physician reviewer, who may refer the case to the Quality Management/Utilization Management Committee. According to P/P AP-004, management staff meets weekly to assess complaints and grievances and determine appropriate</p>		<p>the initial action decision.</p> <p>As noted above, the grievance and appeal files evidenced appropriate reviewers. In addition, the documentation was clear as was the transition of the case between CCKY departments and/or vendors.</p> <p>In the prior review, IPRO recommended that CCKY should ensure that quality of care concerns are reviewed by appropriate clinical staff, and that documentation of investigation and resolution is coordinated between the Customer Services, Provider Services, Appeals and Quality Improvement Departments, so that appropriate investigation and resolution can be tracked.</p> <p>The file review findings indicated that the issues identified in the prior review were addressed:</p> <ul style="list-style-type: none"> <li>• Grievances were categorized appropriately (member vs. provider)</li> <li>• No provider grievances had a clinical component</li> <li>• File documentation was easy to</li> </ul>	



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<p style="text-align: center;">State Contract Requirements  (Federal Regulations 438.402, 438.404, 438.406, 438.408,  438.410, 438.414, 438.416, 438.420, 438.424)</p>	<p style="text-align: center;">Prior Results &amp; Follow-Up</p>	<p style="text-align: center;">Review  Determination</p>	<p style="text-align: center;">Comments (Note: For any element that  deviates from the requirements, an  explanation of the deviation must be  documented in the Comments section)</p>	<p style="text-align: center;">Health Plan's and DMS' Responses and Plan  of Action</p>
	<p>categorization, triage and resolution, with trends reported to the Quality Committee and Executive Quality Improvement Committee periodically.</p> <p>The plan's schedule of committee reports indicates quarterly reporting of grievances, and committee minutes reflect this reporting.</p> <p><u>Grievance File Review</u>  Of 30 member grievances and 15 provider grievances, there were 3 member grievances and 6 grievances that were identified as provider grievances that may have had a clinical component, although it was not entirely clear from the documentation. Three of these cases do not appear to have been reviewed by clinical staff (although documentation is not always clear).</p> <p><b><u>Recommendation for Coventry Cares</u></b>  The plan should ensure that quality of care concerns are reviewed by appropriate clinical staff, and that documentation of investigation and resolution is coordinated between the Customer Services, Provider Services,</p>		<p>follow and clear with an excellent tracking sheet/case summary.</p> <ul style="list-style-type: none"> <li>• Referrals for QOC were evident</li> <li>• Coordination between units, as well as vendors, was evident in the documentation provided – loop was closed between hand off and return including due dates and follow up when indicated</li> <li>• Investigation was appropriate and thorough</li> </ul>	



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	Appeals and Quality Improvement Departments, so that appropriate investigation and resolution can be tracked.			
The Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.				
The Contractor shall ensure that punitive or retaliatory action is not taken against a Member or service provider that files a grievance or an appeal, or a provider that supports a Member's grievance or appeal.	<p><b>Minimal</b> - The Member Handbook includes language that providers are not punished for supporting expedited appeals. Otherwise, submitted documents (policies, Member Handbook and Provider Manual) do not appear to include language that punitive action will not be taken against a Member or service provider who files a grievance or appeal.</p> <p><b>MCO Response:</b> Grievance and Appeal policies (APP-001, 002, 003, 004, 005, 006, and 008) have been updated to state that no punitive action or retaliation will be taken towards a member or provider in response to an appeal. This is not limited to the</p>	Substantial	<p>APP-001, APP-002, APP-003, APP-004 address the requirement that the plan will ensure that punitive or retaliatory action is not taken against a Member or service provider.</p> <p>The Member Handbook, Section 10 states:            "CoventryCares of Kentucky does not punish your provider in any way for requesting a fast appeal or for supporting your request for a fast appeal." No information related to grievances was found.</p> <p>Lack of retaliation related to filing appeals and grievances was not found in</p>	CoventryCares of Kentucky will update the Provider Manual and Member Handbook to ensure that punitive action will not be taken against a member or service provider who files a grievance or appeal. This will be updated in the Fall 2014 Provider Manual and Member Handbook.



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	expedited appeal process. Policies have been submitted to the Policies & Procedures Committee for review and approval. Copies of the draft policies are included.		<p>the Provider Manual or the provider contract.</p> <p>In the prior review, IPRO noted that the Member Handbook and Provider Manual did not include language that punitive action will not be taken against a Member or service provider who files a grievance or appeal. This was noted only in the Member Handbook as it relates to providers filing or supporting expedited appeals.</p> <p>However, as seen above, the Grievance and Appeal policies (APP-001, 002, 003, 004, 005, 006, and 008) were updated to state that no punitive action or retaliation will be taken towards a member or provider in response to an appeal. This is not limited to the expedited appeal process.</p> <p><b><u>Recommendation for CCKY</u></b>            CCKY should ensure that no retaliation is communicated to both members and providers related to both appeals and grievances by including this in the respective handbook/manual.</p>	
<b>24.1 Grievance Process</b>				



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A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.				
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member.	Minimal - P/P APP-004 indicates that a member may file a grievance within 30 calendar days after the event, and that a grievance can be submitted by the member, authorized representative or provider on their behalf by phone fax written communication or electronic communication. In P/P APP-004 it is noted that written or verbal member consent is needed for a representative to file a complaint on behalf of a member, rather than written consent. The Provider Manual includes the written consent requirement for filing appeals for members, but grievances are not addressed. It should be noted that there was one case file in the provider grievance sample that appeared to be a complaint by a home health provider on behalf of the member regarding home care. There was no consent documentation in the file, although it is not clear if the complaint was pursued, since the only documentation other than the complaint was a note requesting a review.	Substantial	<p>Addressed in P/P APP-002, 003, 004, and 006.</p> <p>Provider Manual, Section 10 Complaint Process for Provider and Members describes the process for a provider to file an appeal on the member's behalf with a signed consent but does not address that a provider may file a grievance on a member's behalf, the process, or the need for consent.</p> <p>In the prior review, IPRO recommended that the requirement for written member consent for a provider to file a grievance on behalf of a member be included in the Provider Manual.</p> <p>This requirement was added to P/Ps but not to the respective handbook/manual for communication to members and providers.</p> <p><b><u>Recommendation for CCKY</u></b>  CCKY should ensure that providers' filing grievances on behalf of members with consent is communicated to both</p>	CoventryCares of Kentucky will update the Provider Manual to include the requirement for written member consent for a provider to file a grievance on behalf of a member. This will be updated in the Fall 2014 Provider Manual.



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	<p><b>MCO Response:</b> Policies APP-002, 003, 004, 006, and 008 have been updated to state written consent is required to for an appeal or grievance filed on behalf of the member. (The contract states an oral appeal or grievance may be made but it must be followed in writing.) Policies will be reviewed and adopted by the Policies and Procedures Committee.</p>		members and providers by including this in the respective handbook/manual.	
<p>Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.</p>	<p><b>Minimal</b> - Written acknowledgment of receipt of the grievance within five days, to include expected resolution date, is included in P/P APP-004, and is to be sent by the Customer Service Representative or Appeal Coordinator. This information is also included in the Member Handbook.</p> <p><u>Grievance File Review</u>            Of 30 reviewed grievance files:</p> <ul style="list-style-type: none"> <li>• 7/30 files included an acknowledgement letter with expected resolution date sent within 5 working days.</li> <li>• 1/30 cases had an acknowledgement letter with expected resolution date sent more than 5 working days after receipt.</li> <li>• 9/30 files included an acknowledgment</li> </ul>	Substantial	<p>P/P APP-004 addresses this requirement</p> <p><u>Grievance File Review</u>            File review demonstrated that issues related to acknowledgement letters identified in the prior review have been largely resolved, with the exception of a few cases where the acknowledgement letters were sent late.</p> <p><u>Member Grievance – Random File Review</u>            8 of 10 files acknowledgment letter were sent timely.</p> <p><u>Member Grievance – Quality File Review</u>            9 of 10 files acknowledgment letter were sent timely.</p> <p><u>Provider Grievance File Review</u></p>	<p>1) CCKY has successfully implemented the Grievance Audit tool and has had successful quality scores.</p> <p>2) CCKY has a grievance representative who acts as the liaison between departments regarding grievances. She assembles the electronic files for grievances and makes sure all required communication, research and corrective actions are carried out.</p> <p>3) A tracking log has been required to track errors for CSO and the Grievance Liaison. CCKY has a back-up should the Liaison be out of office.</p> <p>4) The Grievances and Appeals Manager, Grievance Liaison and back-up ALL review daily reports to make sure all necessary communications are sent, and that</p>



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	<p>letter that did not reference a resolution date, but rather had language thanking the member for keeping in touch.</p> <ul style="list-style-type: none"> <li>• 2/30 files included a notation that an acknowledgement letter was sent within five days, but there was no copy of the letter in the file so content (expected resolution date) could not be reviewed.</li> <li>• There were 10/30 files with no acknowledgment letter or mention of letter. Five of these cases documented phone calls with members. In one case, the complaint was resolved on the same day but there was no acknowledgment letter or resolution letter. Some cases had very sparse documentation. One of these cases had a notation that the member should be told to appeal after calling to complain about misinformation on a denial letter, but there is no other documentation in the file.</li> <li>• The remaining 1/30 files noted that an acknowledgment should be sent, but there was no documentation that it was sent and no copy of a letter.</li> </ul> <p><b>MCO Response:</b> CoventryCares of</p>		<p>5 of 5 acknowledgement letters were sent timely.</p> <p>In response to prior findings, CCKY implemented several new processes and procedures and developed a new system for processing grievances including:</p> <ul style="list-style-type: none"> <li>▪ Implementation of Quality Check tool for Grievances. Quality Checks are done weekly and metrics are reviewed by senior management with corrective action taken, as needed.</li> <li>▪ A team member has been assigned responsibility for tracking grievances and ensuring timeliness, compliance, and quality. Other team members are trained as back-up.</li> <li>▪ The responsible staff member uses daily reports to monitor inquiries coded as grievances and any issues that require action. The staff member checks and if a complaint is closed without all necessary components, the case will be reviewed and re-coded correctly or re-opened as a complaint and acknowledged. The report is viewed by the Manager and</li> </ul>	<p>complaints closed by CSO are caught and handled correctly.</p> <p>*** As an addition, a Complaint Checklist function will be added to our systems. This will allow for additional data to be tracked. It will also <b>prevent CSO, or another third party from closing an issue coded as a complaint.</b> Only the G&amp;A Department can close the issues. Coding these issues as complaints will also force an issue to be sent to the proper location to be worked. This feature should do away with incorrectly handled complaints.</p>



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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>Kentucky has made many improvements to the Grievance System in 2013. Improvements include:</p> <ol style="list-style-type: none"> <li>1) Implementation of Quality Check tool for Grievances. Management performs the Quality Check weekly. Metrics are submitted to senior management to review and identify corrective action, as needed.</li> <li>2) A team member has been assigned to be fully responsible for handling Grievances. Remaining team members are full trained in handling Grievances for back-up and during the principal employee's leave. This individual dedicates their time to tracking grievances and ensuring timeliness, compliance, and quality.</li> <li>3) A Tracking Log has been created to track issues opened as complaints but not worked as complaints. The Tracking Log assists the Grievance and Appeals manager in identifying issues related to staff training for the Grievance and Appeals team as well as the call center staff. Issues</li> </ol>		<p>Coordinator. A weekly report is sent to the grievance coordinator for another check.</p> <ul style="list-style-type: none"> <li>▪ A Tracking Log was created to track issues opened as complaints but not worked. The Tracking Log assists the G/A manager to identify staff training issues for both G/A and call center staff.</li> </ul> <p>The current file review reflected the improvements.</p> <p>It was noted in the case files that the tracking system was calculating the due dates incorrectly (+/- 1 – 2 days). This did not impact the timeliness of acknowledgements or resolutions for the files reviewed.</p> <p><b><u>Recommendation for CCKY</u></b>          Acknowledgment letters should be issued within 5 working days of receipt of the grievance.</p>	



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	<p>are reported to the appropriate department's management to reinforce appropriate handling of issues.</p> <p>4) The person responsible for grievances will use daily grievance reports to monitor inquiries coded as grievances, and issues that require action. If any complaint is closed that does not contain all of the necessary components, the case will be reviewed and either re-coded correctly, or will be re-opened as a complaint and acknowledged. This report will be viewed by the Manager and Coordinator to make sure nothing is missed. A weekly report will also be sent to the grievance coordinator so they can double check the closures.</p>			
<p>The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant.</p>	<p>Minimal - Resolution of grievances within 30 calendar days of the date of receipt is included in P/P APP-004, and the resolution is to include a resolution letter to the grievant. As per P/P QI-014, this timeframe applies to a quality of care investigations also.</p> <p><u>Grievance File Review</u></p>	Full	<p>P/P APP-004 addresses this requirement.</p> <p><u>Grievance File Review</u>  A total of 25 files were reviewed (10 member random grievances, 10 member quality grievances, and 5 provider grievances). 25 of 25 were resolved timely.</p>	



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	<p>Of 30 reviewed member grievance files:</p> <ul style="list-style-type: none"> <li>• 14/30 were clearly resolved within 30 calendar days with a written resolution letter.</li> <li>• There were 5/30 cases with written resolution notices that were sent &gt;30 calendar days after receipt of the grievance.</li> <li>• There were 3/30 cases noted to be resolved within 30 days, but there was no documented resolution letter. A notation indicated that a message was left on an answering machine for one case, and another case was resolved on the same day.</li> <li>• For 8/30 files, there was no written resolution notice and no clearly documented resolution date, and in some cases no clear resolution.</li> </ul> <p>In some cases documentation was very sparse. In some cases the complaint may have been handled by Provider Services or Quality Improvement, but there is no evidence in some of the available files as noted above that the complaint was resolved, resolved in a timely fashion and the member notified. P/P APP-004 indicates that the complaint research and resolution should be thoroughly detailed</p>		<p>CCKY implemented improvements and issues identified in 2013 were resolved.</p>	



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	in comments once the complaint is resolved by the appropriate department.  <b>MCO Response:</b> As above.			
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe.	<b>Minimal</b> - This is included in appeal P/Ps APP-001 and APP-002, but there is no reference to extension in the grievance policy APP-004. The plan did provide a sample letter informing the member of the need for an extension for grievance investigation. The sample letter states that more information is needed from the member; there does not appear to be space to describe other reasons for the extension. Of reviewed grievances, there were none for which an extension was requested.  <b>MCO Response:</b> Grievance policies (APP-003,004) have been updated to include the 14 day extension language. Letters KYGA00001 and KYGA00013 (extension letters) are being updated through the plan's letter workgroup to reflect the reason for the extension. The letters will be submitted the Department for approval as required by our contract.	Full	P/P APP-004 and 003 address this requirement.  Sample letters were not submitted for review. CCKY indicated that the letters were to be submitted to DMS for approval. However, letters in the files reviewed were appropriate.  <u>Grievance File Review</u> A total of 25 files were reviewed: 10 member random grievances, 10 member quality grievances, and 5 provider grievances. One extension was granted (member quality grievance file). The letter was in the current format with the reason for extension.	
Upon resolution of the grievance, the Contractor shall mail a	<b>Minimal</b> - Per P/P APP-004, the Appeals	Full	P/P APP-004 addresses the Appeals	



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<p>resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B above, unless the resolution of the grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following:</p>	<p>Coordinator is responsible for a resolution letter. P/P APP-004 indicates that even for Provider Relations-investigated Quality of Service issues, the resolution letter is sent out by the Appeals Coordinator.</p> <p>Files Of 30 member grievances, 19 files included documentation of a resolution letter as noted above.</p> <p>P/P QI-014 indicates that the QI Coordinator sends out member resolution letters for quality of care concerns.</p> <p><b>MCO Response:</b> CoventryCares of Kentucky has a process that handles a Quality of Service complaint through our provider relations department and Quality of Care complaints through our Quality Improvement department. Policy APP-004 and QI-014 are consistent with this process.</p> <p>In order to improve out instances of compliance, we have made the following changes to the Grievance system: See above.</p>		<p>Coordinator's responsibility to send resolution letters.</p> <p>CCKY implemented improvements and issues identified in 2013 were resolved.</p> <p><u>Grievance File Review</u> A total of 25 files were reviewed: 10 member random grievances, 10 member quality grievances, and 5 provider grievances. File review demonstrated that issues related to resolution notices have been resolved. All files contained resolution notices.</p>	



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A. All information considered in investigating the grievance;				
B. Findings and conclusions based on the investigation; and				
C. The disposition of the grievance.	<p>Substantial - Disposition is included in P/P APP-004 and sample grievance and quality of service decision letters provided by the plan.</p> <p>Files Of the 19/30 cases with a resolution notice, 19/19 included the disposition. One disposition was somewhat unclear; the member had been billed by a hospital that refused to bill Coventry. The notice indicated that the hospital had that right. The notice did not provide clarification on the implication for the member, and the member called to clarify weeks later.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The MCO should ensure that all member concerns are addressed.</p>	Full	<p>P/P APP-004 addresses the requirement that the decision letter includes the disposition of the grievance.</p> <p>File review demonstrated that issues related to resolution notices have been resolved. All files contained resolution notices with the required components. Issues related to disposition were resolved. Issues related to clarity were addressed. The language was clear and reading level appropriate.</p> <p>In the prior review, IPRO recommended that the MCO ensure that all member concerns are addressed. As noted above, issues were resolved.</p>	
<b>24.2 Appeal Process</b>				
An appeal is a request for review by the Contractor of a Contractor action.				
A. An action for purpose of an appeal is:				



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(1) the denial or limited authorization of a requested services, including the type or level of service;				
(2) the reduction, suspension, or termination of a previously authorized service;				
(3) the denial, in whole or in part, of payment for a service;				
(4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or				
(5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.				
(6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.				
B. The Contractor shall mail a notice of action to the Member or service provider. The notice shall comply with 42 CFR 438.10(c) regarding language and (d) regarding format and shall contain, but not be limited to, the following:	<p>Substantial - Notice of action content is described in P/P UM-008, Notice of Action.</p> <p><u>Appeal File Review</u>            Of 15 member appeals, one EPSDT appeal did not contain documentation in the file and there was no EPSDT oversample. This file could not be reviewed for notice of action. The 14/15 remaining files included a notice of action. 10/10 provider files included notice of action.</p>	Full	<p>P/P UM-008 addresses this requirement</p> <p>CCKY implemented improvements and the file review demonstrated that issues were resolved.</p> <p><u>Appeal File Review</u>            22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). All files met the requirements for notice of action.</p> <p>In the prior review, IPRO recommended that CCKY ensure that appeal files include complete documentation and</p>	



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	<p><b><u>Recommendation for Coventry Cares</u></b>            The plan should ensure that appeal files include complete documentation and that the notice of action is included.</p>		that the notice of action is included. As described above and as indicated by the file review results, CCKY implemented improvements and issues were resolved.	
(1) the action the Contractor has taken or intends to take;				
(2) the reasons for the action;				
(3) the Member's or the service provider's right, as applicable, to file an appeal of the Contractor action through the Contractor;				
(4) the Member's right to request a state fair hearing and what the process would be;				
(5) the procedures for exercising the rights specified;				
(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and				
(7) the Member's right to have benefits continue pending resolution of an appeal or state fair hearing, how to request				



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the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.				
The notice shall be mailed within ten (10) days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within fourteen (14) days of the date of the action for newly requested services. Denials of Claims that may result in Member financial liability require immediate notification.	Substantial - UM-008 Notice of Action policy includes notice of action within 10 days for previously authorized services. Denial of payment is made on the same day as per policy UM-013, Timeframes for Notice of Action. The timeframe of fourteen days for newly requested services does not appear evident in policies or the Member Handbook.  <b><u>Recommendation for Coventry Cares</u></b> The plan should include timeframes for notice of action for newly requested services in policies.	Full	Addressed in UM-008 Notice of Action and UM-013 Timeframes for Notice of Action.  In the prior review, IPRO recommended that CCKY include timeframes for notice of action for newly requested services in policies. The current P/Ps address each of the required timeframes.	
C. A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the appeal.				



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<p>D. The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. The Contractor shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.</p>	<p>Substantial - As per P/P APP-002, appeal resolution will occur within 30 calendar days.</p> <p><u>Appeal File Review</u>            Of 15 member appeals, 14 included appeal documentation. Of these 14, one was resolved in more than 30 days (Received 11/8, resolution 12/13.) For another member the appeal was resolved within 30 days of receipt of consent for the provider to file the appeal. (Provider appeal received 7/30, consent received 8/13, and resolution 9/10). All 14 appeals were reviewed by a reviewer independent of the initial decision.</p> <p><u>Recommendation for Coventry Cares</u>            The plan should ensure resolution of appeals within 30 calendar days of receipt.</p>	<p>Full</p>	<p>P/P AAP-002 addresses the requirement.</p> <p><u>Appeal File Review</u>            22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). All files met the requirements for appropriate reviewer. All appeals were resolved timely.</p> <p>In the prior review, IPRO recommended that CCKY ensure resolution of appeals within 30 calendar days of receipt. The file review results indicate that this issue was resolved.</p>	
<p>E. The Contractor shall have a process in place that ensures that an oral or written inquiry from a Member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the Member within ten (10) calendar days. The Contractor shall use its best efforts to assist Members as needed with the written appeal and may continue to process the appeal.</p>				



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<p>F. Within five working days of receipt of the appeal, the Contractor shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution.</p>	<p>Substantial - As per P/P APP-002 and APP-003, acknowledgement letters are sent within 5 working days, and include expected date of resolution, which is included in the plan's template acknowledgment letter.</p> <p><u>Appeal File Review</u>            Of 15 member appeals, 14 included appeal documentation (EPSDT appeal did not). 12/14 member appeal files with appeal documentation included acknowledgement letters within 5 days. One acknowledgment letter was not sent within 5 working days (received 9/10, letter sent 9/19.) One EPSDT dental appeal file did not include an acknowledgment letter. As noted above, written consent for one appeal by a provider on a member's behalf was received after 13 days; the acknowledgement letter was sent within 5 working days of receipt of this consent.</p> <p><b>There was one expedited member appeal that had a written resolution within one day and therefore did not require written acknowledgement. 9/10 provider appeals included acknowledgement within 5 working days;</b></p>	<p>Full</p>	<p>Addressed in P/P APP-002.</p> <p><u>Appeal File Review</u>            22 files were reviewed (7 Member, 5 EPSDST, and 10 Provider). All files met the requirements for timeliness of acknowledgment and notices included the expected date of resolution.</p> <p>In the prior review, IPRO recommended that CCKY ensure that the member receives written notice of receipt of appeal (acknowledgement) within 5 days and that the notice includes the expected date of resolution. The file review results indicate that this issue was resolved.</p>	



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	<p>1/10 was sent within 7 days (received 8/29, acknowledgement 9/11).</p> <p><b><u>Recommendation for Coventry Cares</u></b>            The plan should ensure that the member receives written notice of receipt of appeal within 5 days and includes expected date of resolution.</p>			
G. The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.				
H. The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.				
I. The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.				



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J. For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information:	<p>Substantial - The 30 day timeframe for resolution of appeals is included in APP-002 and APP-003, as well as the Member Handbook.</p> <p><u>Appeal File Review</u>            For member appeals, 14/15 files included appeal documentation. 13 member appeal files included a written notice of resolution within 30 days. One file included a resolution letter dated more than 30 days from receipt of the grievance (received 11/8, resolution 12/13).</p> <p>8/10 provider files included resolution letters within 30 calendar days. One case was resolved within 30 days, but the written resolution was dated 33 days from receipt (received 11/8, resolved 12/7, written notice 12/12.) One provider file was incomplete and did not include a resolution or written notice.</p> <p><u>Recommendation for Coventry Cares</u>            The plan should include resolution letter copies in file documentation.</p>	Full	<p>Addressed in P/P APP-002.</p> <p><u>Appeal File Review</u>            22 files were reviewed (7 Member, 5 EPSDST, and 10 Provider). All files met the requirements for timeliness of resolution and resolution notice.</p> <p>In the prior review, IPRO recommended that CCKY ensure that the resolution letter is included in the file documentation. The file review results indicate that this issue was resolved.</p>	
(1) the results and reasoning behind the appeal resolution; and				



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(2) the date it was completed.				
K. The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information:				
(1) the right to request a state fair hearing and how to do so;	Substantial - Of the 5 member appeals with an adverse (upheld or partial) determination, 4/5 included state fair hearing language. 1/5 files with a decision not entirely in member's favor did not appear to contain fair hearing language in the notice of resolution.  <b><u>Recommendation for Coventry Cares</u></b> Fair hearing language should be included in resolution letters for decisions not entirely decided in the member's favor.	Full	Addressed in P/P APP-002.  <b><u>Appeal File Review</u></b> 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). 16 of 22 appeals were upheld. All upheld appeals met the requirements that the resolution notice contain the right to a State Fair Hearing (SFH) and how to do so.  In the prior review, IPRO recommended that CCKY ensure that the resolution letter for upheld appeals contain the right to SFH. The file review results indicate that this issue was resolved.	
(2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and	Substantial - 1/5 files with a decision not entirely in member's favor does not appear to contain fair hearing language in the notice of resolution.  <b><u>Recommendation for Coventry Cares</u></b> The plan should ensure that the notice of	Full	P/P APP-002 addresses this requirement.  <b><u>Appeal File Review</u></b> 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). 16 of 22 appeals were upheld. All upheld appeals met the requirements that the resolution notice contain the right to continuation of benefits while the SFH is	



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	resolution for decisions not wholly in the member's favor include fair hearing information as specified.		pending.  In the prior review, IPRO recommended that CCKY ensure that the resolution letter for upheld appeals contain the right to continuation of benefits while the SFH is pending. The file review results indicate that this issue was resolved.	
(3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action.	Substantial - 1/5 files with a decision not entirely in member's favor does not appear to contain fair hearing language in the notice of resolution.  <b><u>Recommendation for Coventry Cares</u></b> The plan should ensure that the notice of resolution for decisions not wholly in the member's favor include fair hearing information as specified.	Full	P/P APP-002 addresses this requirement.  <u>Appeal File Review</u> 22 files were reviewed (7 Member, 5 EPSDT, and 10 Provider). 16 of 22 appeals were upheld. All upheld appeals met the requirement that the resolution notice contain notice that the member may be liable for the cost of continued benefits if the SFH upholds the decision.  In the prior review, IPRO recommended that CCKY ensure that the resolution letter for upheld appeals contain that the member may be liable for the cost of continued benefits if the SFH upholds the decision.  The file review results indicate that this issue was resolved.	



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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
L. The Contractor shall continue the Member's benefits if all of the following are met:				
(1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action;	<p><b>Non-Compliance</b> - The Member Handbook and P/P APP-002 indicate that if a member wants their benefits to continue during a state hearing they must file within 10 days of notice of action or appeal decision rather than 30 days from the notice of action. This 10 day timeframe is not included in reference to state hearing in the KYGA00008 upheld appeal decision letter.</p> <p><b>MCO Response:</b> Letter number KYGA00008 is being revised by the plan's letter team to include the 10 day timeframe. The letter will be submitted to the Commonwealth for approval.</p>	Minimal	<p>CCKY revised P/P APP-002 and letter KYGA00008 to include the requirements for continuation of benefits. The 10 day timeframe has been deleted.</p> <p>Member Handbook continues to state that if benefits are to continue during the appeal process, the request must be filed within 10 days.</p> <p>As noted above, CCKY revised its P/P and letter KYGA00008 to meet the requirements for continuation of benefits. However, the 10/2013 version of the Member Handbook still states that the SFH must be requested within 10 days for benefits to continue.</p> <p><b><u>Recommendation for CCKY</u></b> The Member Handbook should be revised to delete the 10 day timeframe.</p>	CoventryCares of Kentucky will revise the Fall 2014 Member Handbook to delete the 10 day timeframe.
(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;				
(3) the services were ordered by an authorized service provider;				
(4) the time period covered by the original authorization has				



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not expired; and				
(5) the Member requests extension of the benefits.				
M. The Contractor shall provide benefits until one of the following occurs:				
(1) The Member withdraws the appeal;	<p>Non-Compliance - This language does not appear in the Member Handbook or policy APP-002 or APP-003.</p> <p><b>MCO Response:</b> Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies &amp; Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval.</p>	Full	CCKY revised P/P APP-002 to address the requirement for conditions under which benefits may be discontinued. The Member Handbook states that benefits will continue during appeal/SFH as long as the member eligible for Medicaid.	
(2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action;	<p>Non-Compliance - This language does not appear in the Member Handbook or policy APP-002 or APP-003.</p> <p><b>MCO Response:</b> Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies &amp;</p>	Full	CCKY revised P/P APP-002 to address the requirement for conditions under which benefits may be discontinued. The Member Handbook states that benefits will continue during appeal/SFH as long as the member eligible for Medicaid.	



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	Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval.			
(3) The Cabinet issues a state fair hearing decision adverse to the Member;	Minimal - This language does not appear explicitly in the Member Handbook or P/Ps APP-002 or APP-003, although there is reference that the member is responsible for paying for services if there is an adverse state fair hearing determination.  <b>MCO Response:</b> Policies APP-002 and APP-003 have been updated to reflect that a member may request a continuation of benefits. The policies will be presented to the plan's Policies & Procedures Committee for review and approval. The Member Handbook is being revised to reflect continuation of benefits. The Member Handbook will be submitted to the Commonwealth for review and approval.	Full	CCKY revised P/P APP-002 to address the requirement for conditions under which benefits may be discontinued. The Member Handbook states that benefits will continue during appeal/SFH as long as the member eligible for Medicaid.	
(4) The time period or service limits of a previously authorized service has expired.				
N. If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the				



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Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).				
O. If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services.	Substantial - P/P APP-002 indicates that if a decision is in favor of the member, the Appeal Coordinator must update the necessary authorization or notify Health Services to do so. Language regarding payment for services if adverse decision is reversed and prompt and expeditious authorization is not evident in policies.  <b><u>Recommendation for Coventry Cares</u></b> The MCO should include specific language regarding authorization following reversals of decision in which services were not furnished while appeal was pending into policies.	Full	Addressed in P/P APP-002.  In prior review, IPRO recommended that CCKY include language regarding authorization for services were not furnished while appeal was pending into policies. The policy has been revised.	
<b>24.3 Expedited Resolution of Appeals</b>				
An expedited resolution of an appeal is an expedited review by the Contractor of a Contractor action.				
A. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life or health or ability to				



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attain, maintain, or regain maximum function. Such a determination is based on:				
(1) a request from the Member;	<p>Substantial - P/P AP-001 includes member request for expedited appeal, and the process is described in the Member Handbook. There was one expedited appeal among reviewed case files that was a request from a member.</p> <p>P/P APP-001 notes that members must be educated on the right to appeal if they contact Member Services.</p> <p><b><u>Recommendation for Coventry Cares</u></b></p> <p>In one grievance file, the member is concerned about denial of injections and is told he could file an appeal, but the member indicates that he is in too much pain to wait for resolution. There is no documentation that expedited appeal was discussed with the member. While expedited appeal may not have been appropriate for this member, the plan could consider addressing how and when expedited appeals should be discussed with members who contact the plan dissatisfied with an adverse action.</p>	Full	<p>P/P AP-001 Expedited Appeals addresses the requirements for expedited appeal.</p> <p>The Member Handbook addresses this requirement under Expedited (Faster) Appeal.</p> <p><u>Appeals File Review</u> 22 appeals were reviewed and none involved expedited appeals.</p>	
(2) a provider's support of the Member's request;				



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(3) a provider's request on behalf of the Member; or				
(4) the Contractor's independent determination.				
The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.				
B. The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice.				
C. The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.				
E. The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests an expedited resolution or supports a Member's expedited appeal.	Substantial - The Member Handbook indicates that providers are not punished for requesting or supporting a member's request for expedited appeal. AAP-001 does not address this issue. Punitive action against a member is not referenced in the Member Handbook or APP-001.  <b><u>Recommendation for Coventry Cares</u></b>	Minimal	P/P APP-002 states that CCKY will not take any punitive action or retaliate in any way as a result of a member or member's representative filing or supporting an appeal, whether expedited or otherwise.  The Member Handbook states that CCKY will not punish the provider for filing an expedited appeal or supporting the member's expedited appeal request.	CoventryCares of Kentucky will update the Fall 2014 Member Handbook to include assurance that punitive action will not be taken against a member who requests an expedited appeal.



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	The plan should include assurance that punitive action will not be taken against a member who requests an expedited appeal in the Member Handbook and policy.		Retaliation against the member is not addressed.  <b><u>Recommendation for CCKY</u></b> IPRO previously recommended that CCKY include assurance that punitive action will not be taken against a member who requests an expedited appeal in the Member Handbook and policy. P/P AAP-001 addresses the requirement but the Handbook does not.	
F. The Contractor shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the Member or service provider on behalf of the Member.				
G. The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.				
H. If the Contractor denies a request for an expedited resolution of an appeal, it shall:				
(1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and				
(2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice	Substantial - P/P AP-001 documents that the Appeal Coordinator will call the	Full	Addressed in P/P AP-001. The Member Handbook states that the Appeal	



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within two-calendar days.	<p>member if an appeal does not meet expedited criteria and is converted to a standard appeal, and that written notice of denial of expedited appeal will be sent within 2 calendar days. The Member Handbook indicates that the plan will call or write to the member if the regular appeal process will be followed. There were no case files in the sample that were converted from expedited to standard appeals.</p> <p><b><u>Recommendation for Coventry Cares</u></b>            The plan should amend the Member Handbook information regarding a denied request for expedited appeal to be consistent with policy and the contract requirements.</p>		<p>Coordinator will call the member if the appeal does not meet expedited requirements.</p> <p><u>Appeal File Review</u>            No files involved requests for expedited appeal that were converted to standard appeals.</p> <p>In prior review, IPRO recommended that CCKY amend the Member Handbook to address a denied request for expedited appeal. As noted above, the Member Handbook contains the required language.</p>	
I. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.				
<b>24.4 State Hearings for Members</b>				
A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, within thirty (30) days of receiving notice of the Action or within thirty (30) days of the final decision by the Contractor.				



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All documents supporting the Contractor's Action must be received by the Department no later than five (5) days from the date the Contractor receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. The Department will provide the Member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.				
Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.				
<b>27.8 Provider Grievances and Appeals</b>				
The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the Contractor. Provider grievances or appeals shall be resolved within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the provider. If the Provider requests the extension, the extension shall be approved by the Contractor. A Provider may not file a grievance or an appeal on behalf of a Member without written designation by the Member as the Member's representative. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues.	Minimal - P/P APP-003 addresses provider grievances and appeals. Coventry also identifies a category called "claims review", which is not a grievance or appeal but a process for claims issues that providers are encouraged to pursue before filing grievances or appeals. These are documented as an "inquiry" in Navigator. The plan indicated onsite that some grievances and appeals may actually be inquiries, although identified as grievances or appeals. A provider's right to file a grievance or appeal is noted in the Provider Manual and Provider	Full	Addressed in P/P APP-003.  <u>Provider Appeal and Grievance File Review</u> As described previously, 10 provider appeals files and 5 provider grievance files were reviewed. All files were classified correctly and were clear with regard to whether it was an appeal or grievance and whether member or provider. All files were resolved timely. None of the files required an extension.	



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	<p>grievances are described in member grievance policy APP-004, and examples include perceived lack of helpfulness of Customer Service representatives and timeliness of claim payment. P/P APP-003 defines a grievance as an expression of dissatisfaction with policies, procedures or any aspect of health plan functions.</p> <p><u>Grievance File Review</u>            While some provider grievances were on behalf of members and some were claims-related, it appeared that there was some confusion between provider grievances and inquiries among the provider grievance files. In one file the provider was calling to complain about Provider Relations not returning phone calls; a sticky note on file indicates that this was not handled as a complaint. Another case, whose call about a member may not have been a complaint, included a notation that providers do not have a grievance option. The documentation in the file for another member was not clear, although a sticky note indicates that it is not a complaint.</p> <p>As per P/P AAP-003, grievances are acknowledged within five working days</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>for pre-service issues. Appeals are to be acknowledged within 5 working days as per APP-003 and resolved within 30 calendar days with written notice provided. APP-003 does not reference resolution of provider grievances within 30 days, although the Provider Manual does, and APP-004 appears to reference resolution of both member and provider grievances within 30 days. As noted above, 9/10 provider appeals received acknowledgement within 5 days. Only 3/15 provider grievances received an acknowledgement letter, including 2/3 that were member grievances, and one other provider grievance regarding a denial and lack of a return call from Provider Relations.</p> <p>6/15 files in the provider grievance sample included documentation that they were resolved in 30 days.</p> <ul style="list-style-type: none"> <li>• 8/15 grievance files did not include a clear date of resolution.</li> <li>• 1/15 provider complaints was resolved in 34 days.</li> <li>• 9/10 provider appeals were documented as resolved within 30 days.</li> </ul>			



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	<p>There is no reference to fourteen day extension policy in APP-003, although it appears in the Provider Manual for grievances and in member appeal policy APP-002. A sample extension letter for provider appeals KYGA00013 informs the provider that more time is needed for the appeal, but does not request the extension from the provider. P/P APP-003 includes written authorization for appeals to be filed on behalf of members.</p> <p>Written consent for filing appeals for members is included in P/Ps APP-002 and APP-003 and is in the Provider Manual. All provider appeals filed on behalf of a member included consent in the files.</p> <p><b>MCO Response:</b> CoventryCares of Kentucky has made many improvements to the Grievance System in 2013. Improvements include: See Above.</p>			
<b>27.9 Other Related Processes</b>				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.				
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or				



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its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.				
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.				
Documentation regarding the grievance shall be made available to the Member, if requested.				



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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	22	4	2	0
Total Points	66	8	2	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>2.71</b>		

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

**Reviewer Decision:**

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

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



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**Documents**

Policies/procedures for:

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

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

Process for quality oversight of grievance processing

Evidence of quality oversight and follow-up for grievance processing

**Reports**

Quarterly reports of grievances and appeals

**File Review**

Member and Provider grievance files for a sample of files selected by EQRO

Member and Provider appeal files for a sample of files selected by EQRO

QI Committee minutes or other documentation demonstrating investigation and any action taken for individual grievance and appeal files selected for review by the EQRO



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<p align="center"><b>Health Risk Assessment</b> <i>(See Final Page for Suggested Evidence)</i></p>				
<p align="center">State Contract Requirements (Federal Regulation: Not Applicable)</p>	<p align="center">Prior Results &amp; Follow-Up</p>	<p align="center">Review Determination</p>	<p align="center">Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</p>	<p align="center">Health Plan's and DMS' Responses and Plan of Action</p>
<b>34.1 Health Risk Assessment</b>				
<p>The Contractor shall have programs and processes in place to address the preventive and chronic healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.</p>				
<p>The Contractor shall conduct initial health screening assessment of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.</p>	<p>Minimal - P/P CM-022 documents health screening assessment for new members within 90 days and within 30 days of enrollment for pregnant members. Assessment tools were provided that provide evidence of assessment of members' needs (Medicaid Regulatory Assessment, Good Health Profiles).</p> <p><u>HRA File Review</u> The plan provided only 3/50 files for review, so it could not be ascertained how frequently timely health screening was conducted. Of the 3 files provided with completed Health Risk Assessments (HRAs), one did not provide a clear date of completion so it is unclear when it was completed. The others were completed timely.</p> <p><b>MCO Response:</b> CoventryCares of Kentucky handles the Medicaid Regulatory assessment in-house and not as a portion of the Health Risk Assessment (HRA) contracted to NRC. NRC Good</p>	<p>Minimal</p>	<p>P/P CM 022 Health Risk Assessment Member Participation describes the process and procedure for health risk screening for special needs of new members within 90 days of enrollment and 30 days for members believed to be pregnant, who if pregnant will be referred.</p> <p>P/P CM 021 Health Risk Assessment outlines the outreach procedure for health risk assessment that is conducted by the plan's contracted vendor, which includes at least three outreach attempts on three different days and both telephonic and mailed outreach. As noted by the plan in response to last year's findings, this assessment is a screening to assist in stratifying members' risks and the plan improved the process by which new member files are provided to the vendor by the plan. The vendor process for outreach is described in the vendor's NRC</p>	<p>The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or</p>



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	<p>Health Profile is a screening tool that assists in stratifying a Member's risks and appropriateness for case management. The Medicaid Regulatory assessment is completed by a CoventryCares of Kentucky case manager within 30 days of member enrollment into case management.</p> <p>The NRC Good Health Profile assessment completion date is listed in the enclosed spreadsheet for member as noted in your findings.</p> <p>Through the EQRO response process, CoventryCares of Kentucky identified the file extract sent to NRC was flawed. Members, who became eligible after the extract was sent on the 8<sup>th</sup> of each month, were not sent to NRC. The extract has been corrected. CoventryCares of Kentucky has asked NRC to review all the members affected by the erroneous file extract and to perform and HRA if the (member is still Medicaid eligible and a Coventry member.</p>		<p>Health Risk Assessment Data Collection policy that the plan provided. HRA data are included as a data source for member identification for case management for members with special health care needs (P/P CM-017) and complex case management (P/P CM-004).</p> <p><u>HRA File Review</u>            The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained how frequently timely health screening was conducted. Documentation was received in the form of a call log for 11 members. 5 had at least 3 attempts. 1 had a hang up. 6 had outbound consent which meant that an automated questionnaire was performed. Samples of the HRA were provided. Only attempts to contact member are by phone. 3 members were enrolled prior to auth date and CCKY will look at the logic.</p> <p>NOTE: CCKY stated that only "new" members to Medicaid are required to receive an HRA and that the majority of the members in the sample were existing members from KY Spirit.</p> <p><u>Recommendation for CCKY</u>            All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made</p>	<p>with a chronic condition, were referred to the case management team for immediate outreach.</p> <p>When IPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP.</p> <p>As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs</p>



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			available for EQRO review.	to indicate the attempts at welcome call to the former KSHP membership.  This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire.	Minimal - P/P CM-022 includes making reasonable efforts to contact members. As per policy CM-021, the plan's contracted vendor conducts three calls at three different times on three different days; if still unable to reach the member, a letter is sent to the member to call the vendor on a toll free number. The HRA will be completed on the phone or mailed if requested. A detailed process for contacts is outlined in the document National Research Corporation Health Risk Assessment Data Collection Policy.  Although by policy completed HRAs are given to the plan for review, only 3/50 requested files were provided to the IPRO reviewer. For one of the files, there is documentation of multiple attempts at calls and letters between 11/29/12	Minimal	P/P CM 022 includes reasonable efforts to contact members as per contract language. The process is described in P/P CM 021 and also in the vendor's NRC Health Risk Assessment Data Collection policy. At the onsite CCKY mentioned that they do not outreach in person.  The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained how frequently timely health screening was conducted. Documentation was received in the form of a call log for 11 members. 5 had at least 3 attempts. 1 had a hang up. 6 had outbound consent which meant that an automated questionnaire was performed. Samples of the HRA were provided. Only attempts to	The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who



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	<p>and 1/14/13 until the HRA was completed on an unclear date. The other two files were completed timely. It could not be ascertained how many attempts were made for the 47 files not provided for review.</p> <p><b>MCO Response:</b> As mentioned above, the 47/50 files without contact activity were the result of a flawed identification process. Members who are correctly identified and transmitted to NRC will have contact activity that is demonstrated in the enclosed spreadsheet (NRC Member Contact Activity).</p>		<p>contact member are by phone.</p> <p>NOTE: CCKY stated that only "new" members to Medicaid are required to receive an HRA and that the majority of the members on the sample were existing members from KY Spirit.</p> <p><b>Recommendation for CCKY</b>            All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.</p>	<p>completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach.</p> <p>When iPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP.</p> <p>As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were</p>



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				<p>not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership.</p> <p>This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.</p>
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.	<p>Substantial - P/P CM-022 indicates that this information should be included in Health Risk Assessments, and the tools used to collect HRA information contain these elements, including the Medicaid Regulatory Assessment. Of the three completed HRAs submitted, 2/3 included demographic information. 3/3 files included current health and behavioral status to determine need for care management, disease management, behavioral or other health services.</p> <p><b><u>Recommendation for Coventry Cares</u></b> HRA files should include demographic</p>	Minimal	P/P CM 022 includes this information to be collected (need for care management, disease management, behavioral health services and/or other health/community services. The Good Health Profiles questionnaire (initial screening) includes current health status, demographics, medications, chronic conditions including behavioral conditions, and behavioral risks. The plan provided a template Child Health Screening Tool that addresses all required areas in detail, and a Maternity Health Profiles that is also very detailed and targeted to obstetric risks. These two documents include detailed demographic	The Kentucky Spirit Health Plan exited the Kentucky Medicaid managed care market suddenly in July 2013. All former KSHP members were assigned an effective date with their new MCO of July 6, 2013. As a result, CoventryCares of Kentucky could not determine if KSHP had performed a health risk assessment for the member. To ensure that members were provided a smooth transition to CoventryCares in light of their former MCO's sudden exit, CoventryCares elected to reach out to each former KSHP member with a welcome call. During the welcome call members were asked questions about



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	information.		<p>information.</p> <p>The plan did not provide any files for review of the 25 members in the sample. It could not be ascertained whether demographic information would be included.</p> <p><b><u>Recommendation for CCKY</u></b>            All members new to CCKY should receive an HRA. Outreach attempts for completion of an HRA should be documented and made available for EQRO review.</p>	<p>their health care needs and if the member's response triggered a risk, the member was transferred to a nurse who completed a health risk assessment for the member. Members identified as needing immediate care, as pregnant, or with a chronic condition, were referred to the case management team for immediate outreach.</p> <p>When iPro pulled the universe of new members for CoventryCares, the majority of the "new" members were former KSHP members. The former KSHP membership should have been excluded from the universe as the obligation to complete a HRA is that of the member's first MCO – in this case, KSHP.</p> <p>As a result of the overly broad universe, the sample selected skewed to select members from the former KSHP membership instead of members who should receive an HRA under the contract terms (new to Medicaid eligibility within the past twelve months and pregnant members). As a result, the members selected as part of the sample may not have an HRA completed by CoventryCares as we were not obligated under the contract to perform an HRA for the former KSHP membership. Where an HRA was completed for one of these</p>



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				<p>members, it was where CoventryCares exceeded the contractual requirements to ensure former KSHP members were not harmed by the sudden exit of their MCO. CoventryCares provided the auditors copies of the outgoing call logs to indicate the attempts at welcome call to the former KSHP membership.</p> <p>This explanation was given to the on-site auditors on multiple occasions. A new universe excluding the former KSHP members should have been generated or credit provided for the extra efforts undertaken by CoventryCares of Kentucky. However, the auditors have erroneously identified this as an area for which the plan was not fully compliant. CoventryCares of Kentucky respectfully disagrees with this finding and request this finding be rescinded.</p>
The Contractor shall use appropriate healthcare professionals in the assessment process.				
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventative services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions.	Substantial - As per P/P CM-022, members are encouraged to contact their PCP and schedule a PCP visit. Assisting the member with an appointment is not specifically referenced. Of the 3 completed HRAs submitted for review, 0/3 required assistance with a PCP appointment, as they had either already had an appointment or had one scheduled.	Full	P/P CM 022 includes description of HRA as a participatory process, and notes that members are encouraged to contact their PCP and schedule an appointment upon completion of the HRA, as well as develop a personal health plan. Language has been added to P/P CM 022 that indicates that members identified as high risk that require assistance in setting up an appointment will	



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	<p><b><u>Recommendation for Coventry Cares</u></b>            The MCO should ensure that members are offered assistance by policy if unable to schedule on their own.</p>		be assisted by the case manager.	
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.				



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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	1	0	3	0
Total Points	3	0	3	0

**Overall Compliance Determination:**

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

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

**Reviewer Decision:**

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

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



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### Health Risk Assessment

#### Suggested Evidence

##### Documents

Policies/procedures for:

- Initial health screening assessment (including initial health screening tool)

##### File Review

File review of a sample of cases selected by the EQRO

##### Reports

Quarterly reports on the number of new member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals

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



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<b>Quality Assessment and Performance Improvement: Structure and Operations – Credentialing</b> <i>(See Final Page for Suggested Evidence)</i>				
<b>State Contract Requirements (Federal Regulation 438.214)</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>
<b>27.2 Provider Credentialing and Recredentialing</b>				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,				
defining the scope of providers covered,				
the criteria and the primary source verification of information used to meet the criteria,				
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.				
The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.				
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.				
Providers required to be recredentialled by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists,				



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State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.				
The contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.				
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.				
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.				
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in				



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<b>State Contract Requirements (Federal Regulation 438.214)</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>
accordance with the Department's policies and procedures.				
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;				
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;				
C. A review of the credentialing policies and procedures by the formal body;				
D. A credentialing committee which makes recommendations regarding credentialing;				
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;				
F. Written procedures for the termination or suspension of Providers; and				
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.				
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Substantial - P/P CP - 001 addresses this requirement. CVC Policy and Procedures also addresses this	Substantial	P/P CP – 001 Provider Types, Requirement, Rights address this requirement.	Effective 7/21/2014, hiring of a SR Credentialing Analyst onsite at the Health Plan will provide resolution moving forward.



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<b>State Contract Requirements</b> <b>(Federal Regulation 438.214)</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>requirement.</p> <p>During the onsite review, IPRO reviewed 10 PCP credentialing files and 10 Specialist credentialing files with the following results:</p> <p><u>PCP Files:</u></p> <p>1 PCP – Unable to determine hospital privileges.</p> <p>2 PCPs – No evidence of hospital affiliations.</p> <p>1 PCP – Out of state License (no license in KY).</p> <p><u>Specialist Files:</u></p> <p>1 Specialist – Not a specialist – an Internal Medicine physician with no secondary specialty.</p> <p>1 Specialist – unable to determine board certification.</p> <p>1 Specialist – out of state license (no license in KY).</p> <p>Overall, although information was presented, the files were inconsistently organized.</p> <p>Coventry Cares advised during the onsite review that the Credentialing Committee will be located locally in</p>		<p><u>Credentialing File Review</u></p> <p>IPRO reviewed 10 PCP credentialing files and 10 Specialist credentialing files with the following results:</p> <p><u>PCP Files</u></p> <p>10/10 files reviewed were fully compliant.</p> <p><u>Specialist Files</u></p> <p>8/10 files were compliant. 1 specialist – Recredentialed after 3 years 2 months.</p> <p>1 specialist – No signed attestation. No evidence of credentialing. MCO states that facility conducts credentialing for this specialist.</p> <p>Overall, although information was presented, the files were inconsistently organized. Provider information was stored in both the Corporate and MCO systems which prevents the MCO from maintaining one complete, consistent provider file.</p> <p><b><u>Recommendation for CCKY</u></b></p> <p>Files provided should include complete most up to date information. The MCO should include copies of the most recently signed attestation with the provider files.</p>	<p>Responsibilities of this role will include verification of all provider credentials, ongoing monitoring and managing of provider credentialing files in accordance with P/P CP- 001 Provider Types, Requirement, and Rights.</p>



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	Kentucky beginning April 2013.  <b><u>Recommendation for Coventry Cares</u></b> Files provided should include complete information. The MCO should include a provider profile in the physician's chart. A provider profile aids the MCO during the recredentialing period regarding over/under utilization and grievances from members.			
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.				
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;				
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not Board Certified.				
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;				
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;				
F. Previous five (5) years work history;				



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<b>State Contract Requirements (Federal Regulation 438.214)</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>
G. Professional liability claims history;				
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;				
I. Current, adequate malpractice insurance, as verified through attestation;				
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;				
K. Documentation of curtailment or suspension of medical staff privileges;				
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;				
M. Documentation of censure by the State or County professional association; and				
N. Most recent information available from the National Practitioner Data Bank.				
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;				
B. Lack of present illegal drug use;				
C. History of loss of license and felony convictions;				



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D. History of loss or limitation of privileges or disciplinary activity;				
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and				
F. Applicant attests to correctness and completeness of the application				
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;				
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and				
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.				
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and/or as required by law.				
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.				
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors				



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organizational standards and this contract.				
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:				
A. A current license to practice;				
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;				
C. A valid DEA, if applicable;				
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;				
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and				
F. A current signed attestation statement by the applicant regarding:				
1. The ability to perform the essential functions of the position, with or without accommodation;				
2. The lack of current illegal drug use;				



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3. A history of loss, limitation of privileges or any disciplinary action; and				
4. Current malpractice insurance.				
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :				
A. The national practitioner data bank;				
B. Medicare and Medicaid;				
C. State boards of practice, as applicable; and				
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.				
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.				
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				



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The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.				
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.				
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.				
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.				
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.				
The Contractor shall use the provider types summaries				



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listed at: <a href="http://chfs.ky.gov/dms/provEnr/Provider+Types.htm">http://chfs.ky.gov/dms/provEnr/Provider+Types.htm</a>				
<b>28.1 Network Providers to be Enrolled</b>				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early				



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<p>and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members.</p> <p>Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.</p>				
<p>Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the OSCAR file provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.</p>				



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<p>The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.</p>				
<p>If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.</p>				
<p>The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.</p>				
<p><b>28.2 Out-of-Network Providers</b></p>				
<p>The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a format specified by the Department report all out-of-network utilization by Members.</p>				
<p><b>28.3 Contractor's Provider Network</b></p>				
<p>The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing</p>				



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<p>standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.</p>				
<p><b>28.4 Enrolling Current Medicaid Providers</b></p>				
<p>The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid</p>				



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provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.				
<b>28.5 Enrolling New Providers and Providers not Participating in Medicaid</b>				
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid Provider number.				
<b>28.6 Termination of Network Providers or Subcontractors</b>				
Any Provider or Subcontractor who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation.				



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The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Department will notify the Contractor of voluntary terminations within five business days via email.				
The Contractor shall notify the Department of suspension, termination, and exclusion from Contractor's network taken against a Provider within three business days via email. The Contractor shall notify the Department of voluntary terminations within five business days via email. The Contractor will provide all terminations monthly, via the Provider Termination Report as referenced in Appendix K. The Contractor shall terminate the Provider effective the same date as the Medicaid program termination.				



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**Scoring Grid:**

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

**Overall Compliance Determination:**

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

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

**Reviewer Decision:**

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

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

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



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**Suggested Evidence**

### Documents

Policies and Procedures for:

- Enrollment of network providers
- Enrollment of out-of-network providers
- Provider Credentialing and Recredentialing including delegated credentialing
- Monitoring of provider sanctions, complaints and quality issues between recredentialing cycles
- Altering conditions of participation
- Termination/Suspension of providers
- Initial and ongoing assessment of organizational providers

Credentialing Committee description, membership, meeting agendas and minutes

### Reports

Reports of oversight of delegated credentialing

Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination

Sample provider file report of provider credentialing for DMS Fiscal Agent

Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

### File Review

Sample of Credentialing and Recredentialing files for varied provider types selected by the EQRO



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



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



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<b>A. Acceptable</b>				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;				
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and				
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.				
<b>B. Unacceptable</b>				
(1) Office phone is only answered during office hours;				
(2) Office phone is answered after hours by a recording that tells Members to leave a message;				
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and				
(4) Returning after-hours calls outside of thirty (30) minutes.				
<b>28.7 Provider Program Capacity Demonstration</b>				
The Contractor shall assure that all Covered Services are				



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as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of Medically Necessary services.				
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.				
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:				
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.				



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<p>B. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four (24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals. Specialists shall be commensurate with the subpopulations designated by the Department, and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age.</p>	<p>Minimal - Addressed in P/Ps PR 006, Accessing Appointment Availability and PR – 002, Provider Accessibility and Availability.</p> <p>Evidence of monitoring provider compliance with hours of operation, including after-hours availability was not available. Geo Access reports were provided and are discussed below.</p> <p><b>MCO Response:</b> Coventry Cares has instituted a “Secret Shopper” program, overseen by our regional Vice President of Quality Improvement. Among other things, the “Secret Shopper” program randomly checks on providers to ensure minimum accessibility requirements are met. The first Secret Shopper cycle was completed in-house. Based on the results, the plan has contracted with CareCall to perform a follow-up access and availability survey before the close of third quarter 2013.</p>	Full	<p>PR 006, Accessing Appointment Availability addresses specialty care appointments not to exceed 30 days, 48 hours for urgent care and BH services for emergency care with stabilization within 24 hours.</p> <p>MHNet Utilization Improvement Manual chapters 4 and 6 were provided to show adherence to Behavioral Health services. A copy of the Mental Health Associates practitioner agreement was also provided.</p> <p>Per CCKY Report #16, Summary of QI Activities, the Secret Shopper survey was completed in Q3 2013. Results were submitted to and discussed by the EIC in December 2013 and an internal CCKY corrective action plan developed.</p>	
<p>C. Immediate treatment for Emergency Care at a health</p>				



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State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.				
D. Hospital care for which transport time shall not exceed thirty (30) minutes, except in non-urban areas where access time may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) minutes.				
E. General dental services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.				
F. General vision, laboratory and radiology services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.				
G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.				
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;				
B. FQHCs and rural health clinics;				



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C. The Kentucky Commission for Children with Special Health Care Needs; and				
D. Community Mental Health Centers				
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.	<p>Non-Compliance - Documents provided do not include the requirement for advising the Department if agreements are not established with the providers listed above.</p> <p><b>MCO Response:</b> Coventry Cares of Kentucky currently has contracts with all teaching hospitals and FQHCs located in Kentucky and with the Kentucky Commission for Children with Special Health Care Needs. In addition, Coventry Cares of Kentucky has a contractual relationship with all Community Mental Health Centers through its subcontractor, MHNet. Also, all RHCs have been recruited and the majority are participating with Coventry Cares of Kentucky. Coventry Cares will revise its Policies and Procedures to include provisions for advising the Department if at any time any of these providers are not</p>	Full	<p>Policy ND-001 states that the Department will be notified if agreements are not established for the four provider types listed above.</p> <p>ND-003 Selection and Retention of Network addresses this requirement.</p>	



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	contracted.  Policy ND-001 has been updated to state that the Department will be notified if agreements are not established for the four provider types listed above.			
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.				
B. Provide reimbursement at rates commensurate with those provided under Medicare.				
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Non-Compliance - P/Ps PR-002 and ND-002 do not address this requirement.  <b>MCO Response:</b> Policy and Procedures will be modified to note that charitable providers are eligible for inclusion in the Coventry Cares of KY Network if credentialing standards are met.	Full	Policy and Procedures ND 003 notes that charitable providers are eligible for inclusion in the CCKY Network if credentialing standards are met.	



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<p style="text-align: center;">State Contract Requirements  (Federal Regulations 438.206, 438.207,  438.208, 438.114)</p>	<p style="text-align: center;">Prior Results &amp;  Follow-Up</p>	<p style="text-align: center;">Review  Determination</p>	<p style="text-align: center;">Comments (Note: For any element that  deviates from the requirements, an  explanation of the deviation must be  documented in the Comments section)</p>	<p style="text-align: center;">Health Plan's and DMS'  Responses and Plan of Action</p>
<p>The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.</p>	<p>Substantial - Policies/procedures provided do not address this requirement.</p> <p><b>MCO Response:</b> Policy ND-001 has been updated to reflect this requirement. However, CoventryCares has met this requirement by providing regular provider files to the Department for Medicaid Services which the Department reviews for access requirements. Additionally, the Department reviewed the network during readiness review in October and November 2011 and again in December 2012. CoventryCares has met this requirement by providing regular provider files to the Department for Medicaid Services which the Department reviews for access requirements</p> <p>Coventry Cares of Kentucky recruited key providers immediately after being awarded the Medicaid Managed Care contract.</p>	<p>Full</p>	<p>Policy ND-001 has been provided to address this requirement. The plan added language to the policy to address reporting to DMS.</p> <p>In response to inquiry, the plan submitted ND-003 which states the plan will make its best attempt to include in its network providers who have traditionally provided a significant level of care to Medicaid Members.</p> <p>Report 80 Provider Change in Network reviewed. Report notes panel size, changes, accepting new members.</p> <p>PR-007 Provider Recruitment Network Shortage Policy states the health plan will notify the Kentucky Department of Medicaid Services of deficiencies and submit a corrective action plan to remedy the area of non-compliance.</p>	



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	<p>Contracts were pursued based on priorities set through review of previous Medicaid utilization to identify and target providers with high utilization for initial recruitment. CoventryCares has contracted with all but nine general acute care hospitals in Kentucky and the major out of state hospitals that have experienced significant KY Medicaid utilization (Vanderbilt, Cabell-Huntington, University of Cincinnati, The Christ Hospital, and Deaconess Healthcare). Additionally, CoventryCares has contracted with 100% of the FQHCs. CoventryCares of Kentucky has not experienced out of network utilization that we were not able to address and assure member access when appropriate.</p> <p>Finally, Coventry Cares of Kentucky provides regular GeoAccess reports to the Commonwealth to track the availability of all services in the network, in compliance with established Commonwealth of</p>			



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



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practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A")				
F. Hospitals (designated by a "H")				
G. After hours Urgent Care Centers (designated by a "U")				
H. Local health departments (designated by a "L")				
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)				
J. Pharmacies (designated by a "X")				
K. Family Planning Clinics (designated by an "Z")				
L. Significant traditional Providers (designated by an "**")				
M. Maternity Care Physicians (designated by a "o")				
N. Vision Providers (designated by a "V")				
O. Community Mental Health Centers (designated by a "M")				
The Contractor shall update these maps to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.	Substantial - P/P PR – 002 provided, however this policy does not address updates.  <b><u>Recommendation for Coventry Cares</u></b> It is recommended that the MCO update the policy to include this requirement.	Full	PR-002 Provider Access & Availability and ND- 002 Availability of Practitioners address this requirement.	
<b>28.9 Expansion and/or Changes in the Network</b>				



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If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify the Department of this situation and submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time-frames to correct the deficiency.				
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.				
<b>30.1 Medicaid Covered Services</b>				
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.				
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to				



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enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.				
After the Execution Date, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2 and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in				



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<p>Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.</p>				
<p>If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.</p>				
<p>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.</p>				
<p>If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided</p>				



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within the Contractor's Network.				
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.				
<b>32.3 Emergency Care, Urgent Care and Post Stabilization Care</b>				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).				
<b>32.4 Out-of-Network Emergency Care</b>				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in accordance with 42 CFR 431.52 and 907 KAR 1:084. These regulations require that the Commonwealth, including Department and its Contractor, cover not only Medically Necessary services due to a medical emergency, but also out-of-state medical services if medical services are needed and the member's health would be endangered if he/she were required to travel to his/her state of residence.				
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit				



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Reduction Act of 2005.				
<b>30.2 Direct Access Services</b>				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.				
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;				
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Substantial - Member Handbook addresses this requirement.  <b><u>Recommendation for Coventry Cares</u></b> It is recommended that oral	Substantial	This is addressed in the Member Handbook under Direct Access Services. P/P UM-020 does not address oral surgery services and evaluations.  <b><u>Recommendation for CCKY</u></b> As noted last year, oral surgery services and	P/P UM-020 has been updated to include oral surgery services and is on the agenda for the next Policies and Procedures meeting to review and approve.



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	surgery services and evaluations by orthodontists and prosthodontists be added to P/P UM-O20.		evaluations by orthodontists and prosthodontists should be added to P/P UM- O20.	
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;				
D. Maternity care for Members under 18 years of age;				
E. Immunizations to Members under 21 years of age;				
F. Sexually transmitted disease screening, evaluation and treatment;				
G. Tuberculosis screening, evaluation and treatment;				
H. Testing for Human Immunodeficiency Virus (HIV), HIV- related conditions, and other communicable diseases as defined by 902 KAR 2:020;				
I. Chiropractic services; and				
J. Women's health specialists.				
<b>32.6 Voluntary Family Planning</b>				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.				
The Contractor shall maintain confidentiality for Family				



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Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.				



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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	5	1	0	0
Total Points	15	2	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>2.83</b>		

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

**Reviewer Decision:**

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

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

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



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**Suggested Evidence**

**Documents**

Policies/procedures for:

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

Process for monitoring of provider compliance with hours of operation and availability, including after-hours availability

Process for monitoring of provider compliance with PCP responsibilities

Sample provider contracts – one per provider type

Provider Manual

Benefit Summary (covered/non-covered services)

Corrective action plan submitted to DMS for inadequate access, if applicable

**Reports**

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability

Monitoring of provider compliance with PCP responsibilities

Provider Access and Availability Reports

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

- Primary care
- Specialty care
- Emergency care
- Hospital care



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

Evidence of evaluation, analysis and follow-up related to provider program capacity reports

Reports of Out-of-Network Utilization

Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring



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**Quality Assessment and Performance Improvement: Access – Utilization Management**  
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<b>20.6 Utilization Management</b>				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.				
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.				
The description shall include the scope of the program;				
the processes and information sources used to determine service coverage;				
clinical necessity, appropriateness and effectiveness;				
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Substantial - UM Program 2011-2012 addresses most of the requirements. P/P UM – 051, Discharge Planning and P/P UM-004, Continuity Coordination of Care address this requirement.  <b><u>Recommendation for Coventry Cares</u></b> It is recommended that triage decisions be addressed in the UM Program.	Full	Addressed in CCKY UM Program Description 2013.	
processes to review, approve, and deny services as				



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State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
needed.				
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.				
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director or the QI Committee.				
The Contractor shall adopt national recognized standards and criteria which shall be approved by the Department.				
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.				
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.				
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.				
The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the				



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Member's condition or disease.				
The reason for the denial shall be cited.				
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.				
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.				
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.				
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.				
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within two working days of providing notification of a decision if the decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.				
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.				



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E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.				
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.				
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Substantial - P/P UM – 017, Monitoring of Over/Under Utilization not provided for review.  UM Program 2011-2012 addresses this requirement.  <b><u>Recommendation for Coventry Cares</u></b> The plan should provide requested documentation.	Full	P/P UM-017, Monitoring of Over and Under Utilization addresses this requirement. Examples of reports used for monitoring purposes include: select HEDIS measures, adverse events and quality of care issues, UM reports, inpatient utilization, ER utilization, adverse determinations. Reports are reviewed and analyzed by the QM/UM and Service Advisory subcommittees.  This requirement is also addressed in the 2013 UM Program Description.	
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.				
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.				



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The UM program will be evaluated by DMS on an annual basis.				
<b>20.7 Adverse Actions Related to Medical Necessity or Coverage Denials</b>				
The Contractor shall give the Member written notice that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:				
(a) The action the Contractor has taken or intends to take;				
(b) The reasons for the action;				
(c) The Member's right to appeal;				
(d) The Member's right to request a State hearing;	Substantial - The MCO provided the following member letters as evidence: <ul style="list-style-type: none"> <li>• Mem_Medicaid Appeal – Upheld Denial</li> <li>• Mem_Medical Partial Approval letter.</li> </ul> Member Handbook – Grievance and Appeals addresses this requirement.	Full	Addressed in P/P APP-002, Appeals Members and Member Handbook.	
	<b><u>Recommendation for Coventry Cares</u></b> P/P APP – 002, Appeals Members should be revised to include this requirement.			



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(e) Procedures for exercising Member's rights to appeal or file a grievance;				
(f) Circumstances under which expedited resolution is available and how to request it; and				
(g) The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Substantial - Member Handbook – Grievance and Appeals addresses this requirement.  <b><u>Recommendation for Coventry Cares</u></b> P/P UM-008, Notice of Action should be revised to include continuation of benefits.	Substantial	Addressed in Member Handbook. P/P UM-008 Notice of Action does not address this requirement.  <b><u>Recommendation for CCKY</u></b> P/P UM-008, Notice of Action should be revised to include continuation of benefits.	P/P UM-008 has been updated to include continuation of benefits and is on the agenda for the next Policies and Procedures committee meeting for review and approval.
The Contractor must give notice at least: A. Ten (10) days before the date of Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.				
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;				
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);				
3. The Member's admission to an institution where				



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he is ineligible for further services;				
4. The Member's address is unknown and mail directed to him has no forwarding address;				
5. The Member has been accepted for Medicaid services by another local jurisdiction;				
6. The Member's physician prescribes the change in the level of medical care;				
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;				
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.				
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.				
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.				



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<p>If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.</p>				
<p>E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) working days after receipt of the request for service.</p>				
<p>F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.</p>				



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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	3	1	0	0
Total Points	9	2	0	0

**Overall Compliance Determination:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	3	1	0	0
Total Points	9	2	0	0

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

**Reviewer Decision:**

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

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



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**Suggested Evidence**

**Documents**

Policies/procedures for:

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

UM Program Description

Contracts with any subcontractors delegated for UM

Evidence of provider involvement in the review and adoption of medical necessity criteria

UM Committee description and minutes

Process for detecting under-utilization and over-utilization of services

**Reports**

UM Program Evaluation

Monitoring of consistent application of review criteria and any follow-up actions

CAHPS Report

Provider Satisfaction Survey Report

**File Review**

Sample of UM files selected by EQRO



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<b>36. Program Integrity</b>				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix M, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. This plan shall include, at a minimum:				
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;				
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;				
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;				
D. Effective lines of communication between the compliance officer and the organization's employees;				
E. Enforcement of standards through disciplinary guidelines;				



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F. Provision for internal monitoring and auditing of the member and provider;				
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;				
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;				
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;				
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;				
K. Contractor shall provide procedures for appeal process;				
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
M. Contractor shall create a process for card sharing cases;				
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the				



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overpayments collected;				
O. Contractor shall follow cases from the time they are opened until they are closed; and				
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.				
The plan shall be made available to the Department for review and approval.				
<b>10.1 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 member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as				



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identified by the Department.				
Q, A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid services.				
<b>37.15 Ownership and Financial Disclosure</b>				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Minimal - See sub-requirements below.  <b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Full	COM-006 Delegated Vendor Oversight policy was updated in 2013 to address this annual reporting requirement. Added was 'The activities of the DVOC are reported to the Executive Quality Improvement Committee (EQIC)'. CCKY provided the completed ADO for its subcontractors.  DVOC is the Delegated Vendor Oversight Committee.	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;	Minimal - 2012 Annual Disclosure of Ownership provided addressing Coventry Cares. Disclosure information for subcontractors not provided, only contract provisions.  <u>Annual Disclosure Review</u> Coventry Health and Life Insurance Company: 10 officers identified, one name noted on EPLS; Coventry Cares should check accuracy of this finding with officer's SSN.  Coventry Health Care Inc.: 16 officers	Full	CCKY ADO document listed Aetna Health Holdings, LLC (direct ownership) as the only controlling interest of 5% or more.  A total of 6 entities were reviewed and findings are noted below:  1. AM Specialty Health 2. Chamberin Edmonds 3. Coventry Health and Life 4. Coventry Health Care 5. NIA 6. Triad	



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<b>State Contract Requirements</b> (Federal Regulations: 438.602, 438.608, 438.610)	<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>
	identified, none listed on excluded lists.  <b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.		No officers were listed on the excluded list.	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Minimal - 2012 Annual Disclosure of Ownership provided addressing Coventry Cares. Disclosure information for subcontractors not provided, only contract provisions.  <b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Full	ADO information addressed through documentation for CCKY and its subcontractors.	
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than \$250,000 during the immediately preceding twelve-month period;				
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;				



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E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Minimal - Addressed in 2012 Annual Disclosure of Ownership for Coventry Cares. Disclosure information for subcontractors not provided.  <b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Full	ADO information addressed through documentation for CCKY and its subcontractors.	
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Minimal - Addressed in 2012 Annual Disclosure of Ownership for Coventry Cares. Disclosure information for subcontractors not provided.  <b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. ADOs that have been received to date are included. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address this annual reporting requirement.	Non-Compliance	The ADO documentation provided did not address any employment activities with the Commonwealth.  <u><b>Recommendation for CCKY</b></u> ADO documentation should include disclosure of employment with the Commonwealth or any of its agencies.	All employees are screened and attest to any employment that may cause a conflict of interest. Every applicant is specifically asked if they have any employment history with the Commonwealth of Kentucky and to disclose what that employment relationship was. Any questionable relationship is escalated from the recruiter to the plan Compliance Officer and Legal Counsel for review of conflicts. These must be signed off on before hiring can continue. All Board of Directors, Officers, and any person with an ownership or controlling interest is required to complete and submit conflict of interest to corporate compliance/legal. Anyone who had employment with the Commonwealth and their employment relationship cannot easily assessed is asked to obtain a release from the KY Ethics Review Board.
G. The Contractor shall be required to notify the				



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Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.				
<b>State Contract, Appendix M</b>				
<b>ORGANIZATION:</b> The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;				
B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;				
C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;				
D. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest	Non-Compliance - Prioritization of cases not addressed in the documents provided.	Non-Compliance	As part of the onsite interview it was noted that CCKY does not have a written policy	The CoventryCares policy, SIU Medical Case Process" has been updated with the



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potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:	<p><b>MCO Response:</b> SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p><b>IPRO Comments:</b> No change in review determination. The MCO should document the prioritization process in a policy/procedure.</p>		<p>regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national.</p> <p>During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY was to provide a document that detailed the logic, but it was not received.</p> <p><b><u>Recommendation for CCKY</u></b>            CCKY should prepare a document addressing the prioritization of the Fraud, Waste and Abuse (FWA) process for the KY contract.</p>	<p>following language and will be presented to the Policies and Procedures Committee for review and approval.</p> <p>"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;	<p>Non-Compliance - Prioritization of cases not addressed in the documents provided.</p> <p><b>MCO Response:</b> SIU investigators prioritize</p>	Non-Compliance	It was noted at the onsite interview that CCKY is a multi state organization that shares information among state lines of business. The MCO participates in USDOJ quarterly	The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for



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	<p>work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p><b>IPRO Comments:</b> No change in review determination. The MCO should document the prioritization process in a policy/procedure.</p>		<p>meetings and private State quarterly meetings regarding specific providers.</p> <p>CCKY performs data mining to provide cases to the State on a quarterly basis. Algorithms are given to State.</p> <p><b><u>Recommendation for CCKY</u></b>            CCKY should document the prioritization process for the KY contract in a policy and procedure.</p>	<p>review and approval.</p> <p>"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>
<p>(2) High dollar amount of potential overpayment; or</p>	<p>Non-Compliance - Prioritization of cases not addressed in the documents provided.</p> <p><b>MCO Response:</b> SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by</p>	<p>Non-Compliance</p>	<p>As part of the onsite interview it was noted that CCKY does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national.</p>	<p>The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.</p>



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	<p>the affect on members' health and welfare or the potential dollar recovery. SIU data is aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p><b>IPRO Comments:</b> No change in review determination. The MCO should document the prioritization process in a policy/procedure.</p>		<p>During the onsite interview, it was explained that staff of Special Investigative Unit (SIU) put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY was to provide a document that detailed the logic, but it was not received.</p> <p><b>Recommendation for CCKY</b> CCKY should prepare a document addressing the prioritization of the FWA process for the KY contract.</p>	<p>"If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>
<p>(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.</p>	<p>Non-Compliance - Prioritization of cases not addressed in the documents provided.</p> <p><b>MCO Response:</b> SIU investigators prioritize work based on potential impact to the program. Potential impact is measured by the affect on members' health and welfare or the potential dollar recovery. SIU data is</p>	<p>Non-Compliance</p>	<p>As part of the onsite interview it was noted that CCKY does not have a written policy regarding prioritization. The Program Integrity (PI) Plan is across all of Coventry national.</p> <p>During the onsite interview, it was explained that staff of Special Investigative Unit (SIU)</p>	<p>The CoventryCares policy, SIU Medical Case Process" has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.</p> <p>"If the investigation indicates an imminent threat to member safety or a significant</p>



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	<p>aggregated across the entire company. If more resources are needed by a plan, again work is prioritized to assure appropriate focus on the highest impact. In addition, Coventry participates in national fraud prevention associations to keep abreast of trends and patterns.</p> <p><b>IPRO Comments:</b> No change in review determination. The MCO should document the prioritization process in a policy/procedure.</p>		<p>put membership /patient harms issues to the top of the list. Next are financial risks to the MCO or KY. Based on onsite interview, CCKY was to provide a document that detailed the logic, but it was not received.</p> <p><b>Recommendation for CCKY</b>            CCKY should prepare a document addressing the prioritization of the FWA process for the KY contract.</p>	<p>projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps."</p> <p>*By the time a "member imminent danger" case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.</p>
E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;				
F. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.				
<b>FUNCTION:</b> The Contractor shall establish a PIU to identify and				



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refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:				
A. Preventing Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of member and provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.				
B. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;				
C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;				
D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;				
E. Referring potential Fraud, Waste and Abuse cases to the OIG (and copying DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;				
F. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;				
G. Making and receiving recommendations to				



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enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;				
H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;				
I. Providing for internal monitoring and auditing of Contractor and its subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;	<p>Minimal - Internal monitoring and auditing are addressed in the PIP. Provision of quarterly reports to the Department related to subcontractors is noted. It is not evident that Coventry Cares reports internal monitoring and auditing activities for the Contractor itself.</p> <p><b>MCO Response:</b> The plan has launched a Service Advisory Oversight Committee for internal monitoring and audits, as necessary. The organizational meeting was held on April 17, 2013. The next quarterly meeting is scheduled for July 31, 2013. The Service Advisory Committee members and responsibilities are enclosed. Service Advisory Committee Minutes are reported to the Executive Quality Improvement Committee. Minutes of the EQIC are reported to the Department as part of routine state reporting.</p>	Full	<p>Exhibit 1E Code of Business Conduct and Ethics addresses internal personnel. Monthly report 72 is required to be sent to the State.</p> <p>Delegated vendor oversight committee provides this report to the state and meets monthly.</p>	
J. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and				
K. Creating an account receivables process to collect outstanding debt from members or providers and				



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providing monthly reports of activity and collections to the department.				
The Contractor's PIU shall:				
A. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;				
B. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG;				
C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;				
D. Maintain locally cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;				
E. Designate a contact person to work with investigators and attorneys from the Department and OIG;				
F. Ensure the integrity of PIU referrals to the Department. Referrals if appropriate by the unit shall not be subject to the approval of the Contractor's management or officials;				
G. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were				



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received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
H. Run algorithms on claims data and develop a process and report quarterly to the department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;				
I. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;				
J. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;				
K. Report any provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, to the Department within 5 days of the enrollment denial;	<p>Minimal - Coventry noted CP-012 Provider Terminations and Member Moves as evidence, however this document was not provided.</p> <p><b>MCO Response:</b> Please see emails to DMS which document the reporting and the reason for termination or denied enrollment.</p> <p><b>IPRO Comments:</b> Review determination changed to Minimal. Coventry (CVTY) Provider Terms report for 12/12 provided demonstrating reporting to DMS. Process should be documented in a policy/procedure.</p>	Full	CP-012 Provider Terminations and Member Moves addresses that CCKY will submit to the Commonwealth of Kentucky notification of provider's termination. All terminations are reported to the Commonwealth monthly and within 5 days of an enrollment denial; an email is sent to State.	
L. Have a method for recovering overpayments from providers;				



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M. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;				
N. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations; and				
O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.				
<p><b>PATIENT ABUSE:</b>            Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services and OIG.</p>	<p>Non-Compliance - Addressed in PIP: states that cases involving member safety (abuse) are reported to the health plan medical director for review. Does not address requirement for notifying DCBS, DMS and OIG.</p> <p><b>MCO Response:</b> Please see the new policies which will be submitted through the Policies &amp; Procedures Committee for review and approval.</p>	Non-Compliance	<p>The Program Integrity Plan states that cases involving member safety (abuse) are reported to the health plan medical director for review. The Plan does not address requirement for notifying DCBS, DMS and OIG.</p> <p><b><u>Recommendation for CCKY</u></b>            PIP should address notification requirements.</p>	<p>The CoventryCares policy, SIU Medical Case Process” has been updated with the following language and will be presented to the Policies and Procedures Committee for review and approval.</p> <p>“If the investigation indicates an imminent threat to member safety or a significant projected portion of the plans assets, this must be brought to the attention of your Team Leader or Manager immediately for consideration of what actions should be taken to deal with the threat/issue. Manager will consult with the appropriate law department personnel within Plans legal and medical department on next steps.”</p> <p>*By the time a “member imminent danger”</p>



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				case is referred to SIU for investigation it has already been reported to DCBS/OIG/APS under our CM-033 Reporting Alleged Child Abuse or Neglect or CM-34 Reporting Alleged Adult Abuse or Neglect. CCKY does not wait to refer a case to SIU before notifying the proper authorities. The case would be reported and then it would be sent to SIU for further investigation. In cases, where additional evidence of other abuse is discovered during an investigation, the above process would occur.
<b>COMPLAINT SYSTEM:</b> The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process shall contain the following:				
A. Upon receipt of a complaint or other indication of potential fraud or abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;				
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;				
C. Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer				



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the case to OIG; however, the PIU should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;				
D. Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred, the PIU should refer the case and all supporting documentation to the Department, with a copy to OIG;				
E. OIG will review the referral and attached documentation and make a determination as to whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;				
F. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;				
G. If in the process of conducting a preliminary investigation, the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG;				
H. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to the Department and the PIU for appropriate actions;				
I. If OIG opens an investigation based on a complaint				



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received from a source other than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;				
J. If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PIU of the referral. DMS and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
K. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;				
L. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:	<p>Substantial - Addressed in PIP.</p> <p>A sample of 10 program integrity files were reviewed - 5 member files, 4 provider files and one ancillary provider file. Sub-requirement results are presented below. One file appeared untimely: file indicates that the case was closed on 7/13/12 with referral to OIG; referral to OIG sent 11/15/12.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The MCO should ensure that case investigations proceed to closure in a timely manner.</p>	Full	<p>Addressed in the Program Integrity policy.</p> <p><u>Program Integrity File Review</u> 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.</p>	



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(1) Name and address of subject,				
(2) Medicaid identification number,				
(3) Source of complaint,	Substantial - 9 of 10 files were compliant. One file states that a referral was received, however the source of the referral is not specified.  <b><u>Recommendation for Coventry Cares</u></b> The source of referral should be clearly documented in program integrity files.	Full	<b><u>Program Integrity File Review</u></b> 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	
(4) The complaint/allegation,				
(5) Date assigned to the investigator,				
(6) Name of investigator,	Substantial - 9 of 10 files were compliant. One file did not include the name of the investigator.  <b><u>Recommendation for Coventry Cares</u></b> The name of the investigator should be clearly documented in program integrity files.	Full	<b><u>Program Integrity File Review</u></b> 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	
(7) Date of completion,				
(8) Methodology used during investigation,				
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,	Non-Compliance - Files presented included a timeline of activities. A summary of attachments (listing all items pertaining to the investigative report) was not included in the files.  <b>MCO Response:</b> Most cases reviewed were referrals from the Commonwealth. The	Full	<b><u>Program Integrity File Review</u></b> 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	



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	member and/or provider are determined not to be associated with CoventryCares of Kentucky. For a full investigation, please see the attached file which contains facts and supporting documentation.			
(10) All exhibits or supporting documentation,	Substantial - Supporting documentation was not evident in all the files provided. For example, the letter to the OIG was not included (one case); letter to the provider for recovery not included (one case).  <b><u>Recommendation for Coventry Cares</u></b> Coventry Cares should ensure that case files include all supporting documentation.	Full	<b><u>Program Integrity File Review</u></b> 10 files were reviewed: 5 provider files and 5 member files. 10 of 10 files were compliant.	
(11) Recommendations as considered necessary, for administrative action or policy revision,				
(12) Overpayment identified, if any, and recommendation concerning collection.	Substantial - In one file, the MCO approved recovery of \$6,556.85 on 11/18/12. Recovery submitted and education letter sent on 12/10/12 however these documents are not included in the file. File indicates that the case is closed however status/outcome of recovery is not documented.  <b><u>Recommendation for Coventry Cares</u></b> Coventry Cares should ensure that case files include a listing of all pertinent documents and interviews conducted during the investigation.	Not Applicable	No cases presented for overpayment.	
M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all				



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cases including actions taken to implement recommendations and collection of overpayments;				
N. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and				
O. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.				
<b>REPORTING:</b> The Contractor's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure. If any internal component of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG.				
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:				
(1) PIU Case number;				
(2) OIG Case number;				
(3) Provider/Member name;				
(4) Provider/Member number;				



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<b>State Contract Requirements</b> <b>(Federal Regulations: 438.602, 438.608, 438.610)</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>
(5) Date complaint received by Contractor;				
(6) Source of complaint, unless the complainant prefers to remain anonymous;				
(7) Date opened;				
(8) Summary of complaint;				
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);				
(10) PIU action taken (only provide the most current update);				
(11) Amount of overpayment (if any);				
(12) Administrative actions taken to resolve findings of completed cases including the following information:				
(a) The overpayment required to be repaid and overpayment collected to date;				
(b) Describe sanctions/withholds applied to Providers/Members, if any;				
(c) Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;				
(d) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and				



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(e) Make MIS system edit and audit recommendations as applicable.				
<b>AVAILABILITY AND ACCESS TO DATA:</b> The Contractor shall:				
A. Gather, produce, keep and maintain records including, but not limited to, ownership disclosure for all providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Non-Compliance - Coventry noted that this is addressed in the plan's Record Retention Policy, however this policy was not provided for review.  <b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership information from its Subcontractors. Please see ADOs that have been received to date which are enclosed. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to reflect annual reporting requirement.	Non-Compliance	P/Ps provided do not address requirement. Interviewer requested the retention policy at the onsite, but it was not provided.  <b>Recommendation for CCKY</b> CCKY should address record retention requirements in a policy/procedure.	As the plan migrates to the Aetna platform the Records Retention and Destruction policy approved 5/22/14 will be adopted for CoventryCares of Kentucky.  Today, Privacy-016, Storage and Disposal of Hardcopy PII/PHI includes language on records retention as well as UM-31, Clinical Record and Confidentiality and IS-004 Data Availability and Storage.
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;				
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;				
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;				
E. Produce records in electronic format for review				



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State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
and manipulation by the Department and the OIG;				
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and				
G. Provide all contracted rates for providers upon request.				
The Contractor's PIU shall have access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.				
The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or abuse cases.				
In the event no action toward collection of overpayments is taken by the Contractor after one hundred and eighty (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the Contractor takes appropriate action to collect overpayments, the Commonwealth will not intervene.	Non-Compliance - Not addressed in the documents provided.  <b>MCO Response:</b> Collection amounts and amounts collected are provided on state report # 72 monthly. This is a DMS action. Report #72 is enclosed.  <b>IPRO Comments:</b> No change in review determination. Collection activity reported in Report #72 (dated 2013).	Non-Compliance	Not addressed in documents provided.  <b><u>Recommendation for CCKY</u></b> CCKY should include this requirement in policy/procedure.	This continues to be reported in Report #72. Will present to Policies and Procedures meeting for review and approval of CSO-001, Claims Payment Timeliness.
The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover.	Non-Compliance - Per Coventry this was discussed with DMS, and the plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm.	Non-Compliance	CCKY provided a similar response to last year. Per CCKY, this was discussed with DMS, and the plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm. No documentation was provided addressing this	This is not a contract requirement. The plan is awaiting response on how they can put into effect and not create issues with the Enrollment file and payment pmpm.



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<b>State Contract Requirements</b> (Federal Regulations: 438.602, 438.608, 438.610)	<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>
	<b>MCO Response:</b> This is not a contract requirement. Further, CoventryCares of Kentucky cooperated with the MFCU and Cabinet to provide the credentials in spring 2012. The Cabinet took the matter under advisement. No further action or request has been made since that time.		requirement.  <u><b>Recommendation for CCKY</b></u> CCKY should include this requirement in policy/procedure.	



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**Program Integrity**

**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	11	0	0	9
Total Points	33	0	0	0

**Overall Compliance Determination:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	11	0	0	9
Total Points	33	0	0	0

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

**Reviewer Decision:**

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

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

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



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### **Program Integrity Suggested Evidence**

#### **Documents**

Policies/Procedures for:

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

Program Integrity Plan including related policies and procedures

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

Program Integrity Unit description including Compliance Officer position description

Program Integrity Committee description and minutes

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

Provider contract provisions for FWA

Vendor contract provisions for FWA

#### **Reports**

Evidence of PIU preventive actions and ongoing monitoring of MIS data

Monthly state reporting

Quarterly Program Integrity Reports

#### **File Review**

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

ADO files selected by EQRO



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**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**  
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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<b>8.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b>				
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix J. The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.				
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:				
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034*, and who are supported by adequately equipped offices to perform EPSDT services.	Minimal - P/P UM-047 and Provider Manual address this requirement. Q3 2012 MCO #24 report references an EPSDT Provider Reference Manual that was pending committee approval. It is not evident whether this manual has been approved or made available to providers.  Evidence of provider training was not provided. The adequacy of the provider network to provide accessible and fully trained EPSDT providers was not addressed in the documents provided.	Full	P/P UM-028 and the EPSDT Provider Reference Manual address this requirement. Fax Blast to providers refers providers to the CCKY web site to find the manual. The fax blast included CCKY contact information for EPSDT.  Based on onsite interview, EPSDT manual was sent out in 2013. Fax Blast sent in July 2013. Provider reps meet with offices to discuss EPSDT requirements. EPSDT coordinator may also hand deliver the EPSDT manual to providers.	



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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p><b>MCO Response:</b> 1) The EPSDT Provider Manual was approved by the plan's Communications Review Team (CRT) on April 1, 2013. The EPSDT Provider Manual has been posted to the plan's website. The availability of the manual will be announced to providers through a Fax Blast, email and mail distribution to 3,000 Pediatric Providers and 800 health department offices throughout Kentucky.</p> <p>2) The distribution of the EPSDT Provider Manual along with quarterly EPSDT updates in the Provider Newsletter will serve as the primary educational approach for Providers.</p> <p>3) To provide access to the EPSDT Team members, the plan has shared the key contact names and numbers of the EPSDT Team Members for any questions or concerns.</p> <p>4) The plan's Provider Relations and Quality Outreach staff will serve as additional subject matter sources for the Providers.</p> <p>5) Provider Relations Team EPSDT dedicated training session were held on 6/21/13.</p>			



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**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**  
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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	CoventryCares of Kentucky does not require special classification of EPSDT providers. Providers who are eligible under their license to provide services are permitted to provide EPSDT services to CoventryCares of Kentucky members.			
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.				
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.	<p>Substantial - Member Handbook includes the member's right to appeal decisions related to Medicaid services, but does not specify EPSDT services.</p> <p>P/P QI -017 addresses this requirement.</p> <p><u>UM File Review</u>            Five UM decisions related to EPSDT (child members) were reviewed. All 5 files were completed timely and were compliant with UM contract requirements.</p>	Full	<p>Member Handbook addresses this requirement.</p> <p><u>Appeal File Review</u>            Five member appeals related to EPSDT (child members) were reviewed. All files were completed timely and were compliant.</p>	



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<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b> <i>(See Final Page for Suggested Evidence)</i>				
<b>State Contract Requirements</b> <b>(Federal Regulation: Not Applicable)</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>
	<u>Appeal File Review</u> Five member appeals related to EPSDT (child members) were reviewed. No documentation was provided in the file for one case. Another file lacked an acknowledgment letter. The remaining 3 files were completed timely and were compliant.  <u>Recommendation for Coventry Cares</u> The Member Handbook should include appeal rights for EPSDT services. Appeal files should include complete documentation including acknowledgement letters.			
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.				
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.				
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034*. The Primary				



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<b>State Contract Requirements</b> <b>(Federal Regulation: Not Applicable)</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>
Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers may provide treatment if the service is not available with the Contractor's Network.				
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J.				
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.	Minimal - P/P UM-047 addresses tracking of acceptance and refusal of EPSDT services. Evidence of monitoring of receipt/non-receipt of services provided. Evidence of tracking system for monitoring acceptance and refusal of EPSDT services by members was not provided.  <b>MCO Response:</b> CoventryCares of Kentucky is implementing the following actions to address this finding:  1) Develop a tracking system to report and monitor acceptance and refusal of: a) EPSDT screening and b) EPSDT Special Services  2) Utilize existing monthly	Substantial	This is addressed in the NavCare system. The EPSDT Team has chosen to utilize this system to track all inbound and outbound based telephonic conversations with families.  Policy CM-025 EPSDT Referrals presents the process for ensuring timely member compliance. Members are identified through the Cognos PCP Member Detail Report for well child visits. The coordinator follows up with members who have not been compliant with referral appointments for EPSDT services. A consolidated record is maintained in NavCare for each member. A NavCare screen shot along with the process was provided.  A sample Cognos report was to be presented during the onsite visit but was not provided.	CoventryCares of Kentucky will ensure that all reports are presented during future onsite, as requested. A CoventryCares of Kentucky compliance trend report from Cognos is being submitted for the EQRO's files.



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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>reports for tracking of:</p> <ul style="list-style-type: none"> <li>a) Lack of compliance based on frequency of missed visits</li> <li>b) Listing of members with non-assigned Provider and lack of compliance and</li> <li>c) Any member or family who refuses EPSDT Services</li> </ul> <p>3) Implement scheduled member outreach process based on identification of EPSDT visit non-compliance at high level threshold.</p> <p>This is will be accomplished through a system enhancement to NavCare System to add EPSDT data fields for tracking of EPSDT coordinator outreach and follow-up. The request has been submitted and development meetings are scheduled.</p>		<p><b>Recommendation for CCKY</b>  A sample Cognos report should be provided for review.</p>	
<p>H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when</p>				



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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
recommended assessments and treatment are not received.				
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.				
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 be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.				
K. Participate in any state or federally required chart audit or quality assurance study.				
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging	Minimal - P/P UM-047 and the Provider Manual address this requirement.  Upon employment with the MCO	Full	This was addressed through the following documents: KYPR00022 Provider Manual; EPSDT Provider Manual; 07 16 13 Provider Fax Blast – EPSDT Promotion and Education; CCKY Provider Newsletter Volume 1 Issue 1;	



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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.</p>	<p>and annually, customer service and case management staff attend EPSDT training.</p> <p>A formal educational seminar was provided to case management staff.</p> <p>Per the Q3 2012 MCO Report #24, the plan developed an EPSDT Provider Reference Manual that is awaiting committee approval.</p> <p>Evidence of provider training was not provided.</p> <p><b>MCO Response:</b> 1) The EPSDT Provider Manual was approved by the plan's Communications Review Team (CRT) on April 1, 2013. The EPSDT Provider Manual has been posted to the plan's website. The availability of the manual will be announced to providers through a Fax Blast, email and mail distribution to 3,000 Pediatric Providers and 800 health department offices throughout Kentucky.</p> <p>2) The distribution of the EPSDT Provider Manual along with quarterly EPSDT updates in the</p>		<p>EPSDT Educational Fax Blast Attendance Target July 2014. All training was done through electronic media.</p>	



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	<p>Provider Newsletter will serve as the primary educational approach for Providers.</p> <p>3) To provide access to the EPSDT Team members, the plan has shared the key contact names and numbers of the EPSDT Team Members for any questions or concerns.</p> <p>4) The plan's Provider Relations and Quality Outreach staff will serve as additional subject matter sources for the Providers.</p> <p>5) Provider Relations Team EPSDT dedicated training session were held on 6/21/13.</p> <p>CoventryCares of Kentucky does not require special classification of EPSDT providers. Providers who are eligible under their license to provide services are permitted to provide EPSDT services to CoventryCares of Kentucky members.</p>			
<p>M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.</p>				



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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.</p>	<p>Minimal - The MCO provided an Overview of EPSDT Coordinator Functions as evidence for this requirement. This document is not dated; not a formal position description.</p> <p>The EPSDT liaison position is vacant on the organizational chart provided. The EPSDT nurse position is staffed.</p> <p><b>MCO Response:</b> The Medicaid Managed Care Contract states in Section 10.1, "The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided. Responsibility for these functions or staff positions may be provided by, combined with or split among Contractor's departments, people or Subcontractors and carry such titles as Contractor designates and provides to the Department."</p> <p>The role of EPSDT Coordinator is filled by multiple staff. The appointed EPSDT Coordinator as communicated to the</p>	<p>Full</p>	<p>The ORG chart showed 1 EPSDT coordinator position. CCKY stated at the onsite interview that they use a proprietary formula for staffing ratios. ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services.</p>	



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<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b> <i>(See Final Page for Suggested Evidence)</i>				
<b>State Contract Requirements</b> <b>(Federal Regulation: Not Applicable)</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>Commonwealth is Debbie Moorhead, RN, Manager Health Services. Ms. Moorhead has deep experience in working with pediatric and neonatal providers and members. She leads our EPSDT initiative and uses the talents and skills of other clinical and clerical staff to track and monitor the EPSDT population.</p> <p>Please see the enclosed Organizational Chart.</p>			
<b>22.1 Required Functions</b>				
<p>L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.</p>	<p>Non-Compliance - The MCO provided an Overview of EPSDT Coordinator Functions as evidence for this requirement. This document is not dated; is not a formal position description and does not address the required function as stated in the contract requirement.</p> <p><b>MCO Response:</b> The Medicaid Managed Care Contract states in Section 10.1, "The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided. Responsibility</p>	<p>Full</p>	<p>The ORG chart showed 1 EPSDT coordinator position. CCKY stated at the onsite interview that they use a proprietary formula for staffing ratios. ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services.</p>	



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State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>for these functions or staff positions may be provided by, combined with or split among Contractor's departments, people or Subcontractors and carry such titles as Contractor designates and provides to the Department."</p> <p>The role of EPST Coordinator is filled by multiple staff. The appointed ESPDT Coordinator as communicated to the Commonwealth is Debbie Moorhead, RN, Manager Health Services. Ms. Moorhead has deep experience in working with pediatric and neonatal providers and members. She leads our EPSDT initiative and uses the talents and skills of other clinical and clerical staff to track and monitor the EPSDT population.</p> <p>Please see the enclosed Organizational Chart.</p>			
<b>37.9 EPSDT Reports</b>				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT				



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<b>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</b> <i>(See Final Page for Suggested Evidence)</i>				
<b>State Contract Requirements</b> <b>(Federal Regulation: Not Applicable)</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</b> <b>DMS' Responses and Plan of Action</b>
activities, utilization and services and the current Form CMS-416 to the Department.				



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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	5	1	0	0
Total Points	15	2	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>2.83</b>		

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

**Reviewer Decision:**

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

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

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



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

#### Documents

Policies/procedures for:

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

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

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

EPSDT Coordinator position description

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

Process for monitoring compliance with EPSDT services requirements including periodicity schedule

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

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

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

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

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

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

#### File Review

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

#### Reports

EPSDT reports (quarterly and annual 416 reports)

Annual EPSDT report of EPSDT activities, utilization and services



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<b>5.3 Delegations of Authority</b>				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.	Coventry Cares subcontracts with 8 entities including: American Specialty Health (ASH) – chiropractic services Medco – pharmacy services National Imaging – radiology services Triad – musculoskeletal pain management services Avesis – dental services McKesson – advice line MH Net – behavioral health services VSP – vision services  Coventry Cares also contracts with National Research Corporation (NRC) for conduct of Health Risk Assessments for its Kentucky members, and with Chamberlain Edmonds to identify members who may qualify for SSI.			
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.				
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Substantial - Pre-delegation audits were provided for all subcontractors with the exception of ASH: Coventry Cares provided a pre-delegation audit dated 3/18/13. The audit indicates that the MCO has had a contract with ASH since November 2011. A pre-delegation audit prior to the date of delegation was not	Full	CCKY subcontracts with seven (7) entities that provide delegated services including:  American Specialty Health (ASH) – provides chiropractic services	



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	provided.		<p>Avesis – provides dental services (began providing vision services 11/2013)</p> <p>Express Scripts, Inc. – (formerly MedCo) provides pharmacy services</p> <p>McKesson – provides an advice line</p> <p>MHNet – provides behavioral health services</p> <p>National Imaging – provides radiology services</p> <p>Triad – provides pain management services</p> <p>VSP – provides vision services (contract terminated 11/2013 during period of review)</p> <p>CCKY also contracts with National Research Corporation (NRC) which is an entity that conducts Health Risk Assessments and Chamberlin Edmonds which CCKY uses to identify members who may qualify for SSI. These two entities have no delegated services.</p> <p>This requirement is addressed in the Oversight of Delegated Subcontractors Policy.</p>	



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Pre-delegation audits were provided for all subcontractors.	
<p>C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.</p>	<p>Minimal - Coventry Cares maintains a Subcontractor Oversight Committee. During the transition period, the MCO met weekly with subcontractors, eventually reducing to biweekly and currently monthly meetings.</p> <p>Documentation of oversight, ongoing and formal review, was provided for Medco (annual audit December 2012) and Avesis (annual audit October 2012). Evidence of ongoing monitoring and/or an annual audit was lacking for the following:</p> <p>ASH: Coventry Cares provided copies of meeting agendas and minutes for 2012/2013. Performance standard reports were not provided. MCO Report 15 indicates that penalties were assessed for failure to meet timely claims processing standards and for not providing electronic encounter records. Follow-up regarding this issue was not evident in the documents provided. The MCO noted that the annual audit for ASH is currently in process.</p> <p>National Imaging: The annual audit for 2012 (reported January 2013) was provided. Evidence of ongoing oversight including monitoring of subcontractor reporting was not provided.</p> <p>Triad: Evidence of ongoing oversight including</p>	Full	<p>This requirement is addressed in the Oversight of Delegated Subcontractors Policy.</p> <p>Performance is monitored on an ongoing basis (at least quarterly) by means of a Subcontractor Oversight Committee. Meeting minutes from both the Committee and from the Committee's meetings with the subcontractor are provided as evidence of ongoing monitoring.</p> <p>Documentation of ongoing oversight and formal review was provided for the following subcontractors:</p> <p>American Specialty Health (ASH): CCKY provided copies of meeting agendas and minutes for 2013. An annual audit was finalized 12/2013 with a CAP for ASH that will be monitored via quarterly meetings and the annual audit. A Delegation Evaluation Summary Report dated 12/2013 was provided that indicated follow-up on previous corrective action given to ASH.</p> <p>Avesis: CCKY provided evidence of ongoing monitoring (meeting minutes)</p>	



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	<p>monitoring of subcontractor reporting was not provided. Annual audit not due yet.</p> <p>McKesson: Evidence of ongoing oversight including monitoring of subcontractor reporting not provided. Annual audit conducted (November 2012).</p> <p>MHNet: Evidence of ongoing oversight including monitoring of subcontractor reporting not provided. Annual audit conducted (October 2012).</p> <p>VSP: Evidence of ongoing oversight subcontractor reporting provided. Evidence of annual audit not provided</p> <p><b>MCO Response:</b> CoventryCares of Kentucky has completed the delegation audits of ASH and Avesis. Reports to the Executive Quality Improvement Committee on the audits are included.</p> <p>CoventryCares of Kentucky has recently reorganized its structure related to delegated vendor/subcontractor oversight. A new director for Network Development has been hired and will take the lead in Subcontractor Oversight. To prepare for this transition, the Compliance Department and Quality Improvement Department have prepared summaries of individual subcontractor contract deliverables and NCQA requirements. Monthly meetings are</p>		<p>as well as an Annual Audit Summary dated 12/2013.</p> <p>Express Scripts, Inc.: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 1/4/2014.</p> <p>MHNet: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 11/2013.</p> <p>National Imaging Associates (NIA): CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 11/2013.</p> <p>Triad: CCKY provided evidence of ongoing monitoring (meeting minutes) as well as an Annual Audit Summary dated 5/2013.</p> <p>VSP: CCKY provided evidence of ongoing monitoring (meeting minutes) and terminated their contract with VSP on 11/1/2013.</p> <p>Evidence was lacking for the following subcontractors:</p> <p>McKesson: An Annual Audit Summary</p>	



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	scheduled with each subcontractor. Further, bi-monthly meetings of the Subcontractor Oversight Committee are scheduled in which the plan's contract liaisons will report on each subcontractor's performance. The Committee will review the performance and make recommendations for improvement and where appropriate, corrective action.		dated 11/2013 was provided. During the onsite review, CCKY noted that McKesson is monitored by Corporate and provided evidence of correspondence and meeting minutes with corporate regarding McKesson CAP.	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Minimal - Areas of deficiency identified during annual audits resulted in corrective action plans. Results of ongoing monitoring for several subcontractors was not provided; it is not clear whether corrective actions are in place in response to regular reporting for these entities.  ASH was assessed penalties as described above.  <b>MCO Response:</b> Please see corrective action plan monitoring for ASH and Avesis.	Full	This requirement is addressed in the Oversight of Delegated Subcontractors Policy.  Areas of deficiency were identified during annual audit results and corrective action plans (CAPs) were given to ASH, Triad, Avesis and McKesson.  Ongoing monitoring was provided by regular meetings, at least quarterly, with the subcontractors as evidenced by meeting minutes provided by CCKY for Avesis, Triad, McKesson and ASH.	
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.				
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.	Minimal - See sub-elements above.  <b>MCO Response:</b> Please see corrective action plan monitoring for ASH and Avesis.	Full	This requirement is addressed in the Oversight of Delegated Subcontractors Policy.	



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Ongoing monitoring was provided by regular meetings, at least quarterly, with the subcontractors as evidenced by meeting minutes provided by CCKY for Avesis, Triad, McKesson and ASH.	
<b>7.1 Subcontractor Indemnity</b>				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.				
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.				
<b>7.2 Requirements</b>				



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<p>All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.</p>				
<p>The Department's subcontract review shall assure that all</p>				



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Subcontracts:				
A. Identify the population covered by the Subcontract;				
B. Specify the amount, duration and scope of services to 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;				
E. Make full disclosure of the method 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;				
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;				
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;				
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the				



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



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State Contract Requirements (Federal Regulation 438.230)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;				
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	<p>Substantial - 7/8 of contracts are compliant. NCQA certificate for VSP expired 5/3/12.</p> <p><b><u>Recommendation for Coventry Cares</u></b> Current accreditation certificates and survey reports should be maintained for each subcontractor.</p>	Full	<p>URAC accreditation and survey reports were provided for: ASH and Express Scripts.</p> <p>NCQA accreditation and survey reports were provided for: NIA, MHNNet, McKesson, and Triad. Avesis is not accredited.</p>	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.				
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.				
Section 7.2 requirements would be applicable to Subcontractors characterized as Providers/Risk Arrangements including, but not limited to, physicians, hospitals, ancillary providers, IPAs/PHOs, Provider Networks, and Vision Care, Dental and Behavior Health Services; and to those who interact and assist Members including, but not limited to, Radiology Benefit Manager, Disease Management/Case Management, Health Risk Assessments, Pre-Certification Services,				



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PBM, Recoveries, Translation Services and 24-hour Section 7.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.				
<b>7.3 Disclosure of Subcontractors</b>				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of \$25,000 or five percent (5%) of the Subcontractor's operating expense.	<p>Non-Compliance - Coventry Cares did not address this requirement in the documentation provided.</p> <p><b>MCO Response:</b> CoventryCares of Kentucky has requested annual disclosure of ownership (ADO) information from its Subcontractors. Additionally, COM-006 Delegated Vendor Oversight policy has been updated to address ADOs that have been received to date are included.</p>	Substantial	<p>No evidence of an update to the Oversight Policy is evidenced. The Policy provided makes no mention to the reporting requirement levied on the Contractor nor does it include any of the state contractual language.</p> <p>The Annual Disclosure of Ownership information has been provided from each of CCKY's subcontractors.</p> <p><b>Recommendation for CCKY</b> The Oversight Policy should be updated to address disclosure of subcontractors to DMS.</p>	The Oversight Policy is on the Policies and Procedures agenda for an update to reflect the disclosure of subcontractors to DMS.
<b>7.4 Remedies</b>				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.				



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

**Scoring Grid:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	5	1	0	0
Total Points	15	2	0	0

**Overall Compliance Determination:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.83		

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

**Reviewer Decision:**

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

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

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



## KY EQRO ANNUAL REVIEW

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

#### **Documents**

List of subcontractors including type(s) of services provided and date of initial delegation

Contract with each subcontractor

Accreditation certificate and report for each subcontractor

Policies and procedures for subcontractor oversight

Subcontractor Oversight Committee description, meeting agendas and minutes

Documentation of ongoing oversight of subcontractors including follow-up

List of subcontractors terminated during the period of review

Evidence of DMS notification of all new subcontractors and terminated subcontractors

Evidence of disclosure of subcontractor activity to DMS

#### **Reports**

Pre-delegation evaluation report for new subcontractors

Periodic, formal evaluation reports for each subcontractor, including those with accreditation

Subcontractor certificate of accreditation and survey report



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**Quality Assessment and Performance Improvement: Health Information Systems (HIS)**  
*(See Final Page for Suggested Evidence)*

State Contract Requirements (Federal Regulations 438.242)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from 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>17.1 Encounter Data Submission</b>				
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Record set in formats and timelines prescribed by the Department as defined in the Contract.		Full	Policy and Procedure CSO - 002 Claims Processing addresses this. A Business Associate Amendment was also provided for their vendor McKesson.	
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter.		Full	Policy and Procedure CSO - 002 Claims Processing addresses this. A Business Associate Amendment was also provided for their vendor McKesson.	
At a minimum, the Contractor shall be required to electronically provide Encounter Record to the Department, on a weekly schedule.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement.	
Encounter Record must follow the format, data elements and method of transmission specified by the Department.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement.	
All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible.				
The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department.		Not Applicable	No evidence provided that the Department has requested test data files.	
The electronic test files are subject to Department review and approval before production of data.				
The Contractor shall have the capacity to track and report on all Erred Encounter Records.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement. "Report YYYYMM_rejects_skips_not reconciled" show	



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**Quality Assessment and Performance Improvement: Health Information Systems (HIS)**  
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State Contract Requirements (Federal Regulations 438.242)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			how erred records are tracked.	
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounter Record in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounter Records as directed by the Department.		Full	Policy ENC-001 (formerly GEN004) addresses this contract requirement. Standard HIPAA file formats are used.	
All subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.		Full	Addressed in provider and subcontractor agreements.	
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contract person is not available.		Full	CCKY provided meeting minutes for the 8/7/13 and 8/15/13 meetings showing MCO attendance.	
<b>17.2 Technical Workgroup</b>				
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter Record.		Full	CCKY provided example meeting minutes for the 8/7/13 and 8/15/13 meetings showing MCO attendance. During interview, CCKY reported attendance at each call.	
<b>18 Kentucky Health Information Exchange (KHIE)</b>				
The Contractor shall provide all adjudicated Claims data within twenty-four (24) hours of final claim adjudication in support of KHIE. The Contractor shall provide the KHIE with all clinical data as soon as it is available. The Contractor will also share with the KHIE any Member		Not Applicable	The requirement to submit to KHIE was suspended by KDMS in March 2013. Although the requirements were suspended, the MCO shall make a good faith effort to encourage all providers in their network to establish	



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State Contract Requirements (Federal Regulations 438.242)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
patient clinical data.			connectivity with the KHIE.	
The PCPs in the Contractor's network shall be required to connect to KHIE within one (1) year of the effective date of the contract with the Contractor or other schedule as determined by the Department. Furthermore, the Contractor shall encourage all providers in their Network to establish connectivity with the KHIE.		Not Applicable	The requirement to submit to KHIE was suspended by KDMS in March 2013. Although the requirements were suspended, the MCO shall make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE.	
<b>29.1 Claims Payments</b>				
In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims.		Full	Addressed in P/Ps: ENC-001, CSO-001 (Claims Payment Timeliness) and CSO-002 (Claims Processing).  The Operational Performance Reports for 2013 demonstrate compliance with meeting the 30 days standard.	
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.		Full	Policy CSO - 001 Claims Payment Timeliness addresses this requirement. In addition, the Provider Manual chapter B Claim Payments and Processing Time Frames was provided. Report showing prompt pay was also provided.	



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**Quality Assessment and Performance Improvement: Health Information Systems**

**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	11	0	0	0
Total Points	33	0	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	3.0			

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

**Reviewer Decision:**

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

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

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**Quality Assessment and Performance Improvement: Health Information Systems**

**Suggested Evidence**

**Documents**

Policies/procedures for:

- Claims processing
- Claims payment
- Encounter data reporting

Process for verifying the accuracy and completeness of provider and vendor reported data

Process for screening data for completeness, logic and consistency

Evidence of timely and accurate reporting of encounter data to DMS

Process for monitoring compliance with claims payment timeliness requirements

Process for tracking and reporting erred encounter records

Evidence of participation in Encounter Technical workgroup

Method for meeting KHIE requirements

Status of efforts to have PCPs establish connectivity to KHIE

**Reports**

Timeliness of Claims Payment

Results of compliance monitoring for timeliness of claims payment and compliance with prompt pay statute

Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up



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



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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
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.				
<u>CHIPRA</u> means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue their existing program and expands insurance coverage to additional low-income, uninsured children.				
<u>Comprehensive Assessment</u> 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>34.2 Care Management System</b>				
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.				
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.				



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State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.				
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	<p><b>Non-Compliance</b> - Linkage of care coordination with other contractor systems not addressed in the policies provided.</p> <p><b>MCO Response:</b> The current policy (UM-004) has been updated to reflect the on-going coordination of care activities related to quality of care, quality of service, grievances and appeals, case management referrals, adverse events and member service inquiries. Initial policies were prospective based on the start-up nature of the health plan. Processes have evolved as the plan has matured. Please see the revised UM-004 policy as attached.</p>	Full	<p>CCKY indicated that P/P UM-004 had been replaced by P/P CM-035. CCKY provided this policy during the onsite review.</p> <p>CM-035 Continuity and Coordination of Care states that CM, Concurrent Review, Customer Service, and Prior Authorization teams arrange clinical services and work with the member to ensure a physician is selected to coordinate services to address the member's needs.</p> <p>In the interview, CCKY indicated that all grievances, UM activities, and concerns for the DCBS population are routed to the DCBS lead for management.</p> <p>Linkage to the MCO's quality improvement program is demonstrated via the DCBS Satisfaction Survey to evaluate satisfaction with coordination of care. This is a new process therefore; there were no data to share.</p>	
<b>34.3 Care Coordination</b>				



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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 Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.				
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.				



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State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
The Care Plan shall be developed in accordance with 42 CFR 438.208.				
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><b>Non-Compliance</b> - Coventry provided Report 65, Foster Care Report as evidence. This report provides information on members in foster care including enrollment in case management, and disease management, completion of health risk assessments. It does not address measurement of utilization, access, complaints and grievances and satisfaction for this population.</p> <p><b>MCO Response:</b> CM-011 has been updated to reflect utilization, access, complaints and grievances as well as satisfaction.</p> <p>Please also see Policy UM-004, CM-010 and UM-017.</p>	Non-Compliance	<p>The plan submitted CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) P/P. This document outlines the procedures to ensure access to care coordination for all DCBS clients.</p> <p>The plan also submitted CM-010 (Access to Special Needs Providers) P/P which outlines procedures to ensure appropriate and timely access to providers, particularly for Individuals with Special Health Care Needs (ISHCN).</p> <p>UM-017 (Monitoring of Over and Under Utilization) described how the plan will collect, review, analyze and report on utilization data to assess performance as well as the performance of network providers and how this performance impacts the quality of care and well being of members. This P/P is a general policy, and not specific to the DCBS population.</p> <p>After the last audit, the plan stated that they updated CM-011 to address noted deficiencies; however, this P/P still does not address deficiencies, nor did the plan provide evidence to show how they track,</p>	<p>The plan has created a specific population based measure for analysis and comparison to other populations.</p> <p>These measures will allow CoventryCares of KY to confirm access to coordination of care for all DCBS clients. Eligible populations will be identified for both ISHCN members, and a comparable population of members of similar age. Metrics for measures such as annual dental visits, well child visits, adolescent well care and access to PCP's will be tracked for both groups.</p> <p>Secondly, these measures will be compared between the ISHCN and overall populations. A statistical T-test for variation of means will be performed using the sample sizes for each measure. In instances where the ISHCN population shows a statistically significant decrease (at the 95% confidence interval level) in care coordination than the population at large, plans for corrective action will be created to address the discrepancy in care for ISHCN clients.</p> <p>For the "control" group population, we will select a large (&gt;500) random set of members from the general population of enrollees who are between the ages of 12 months and 19 years of age as of December 31 of the</p>



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			<p>analyze, report, and develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.</p> <p>In the interview, CCKY indicated that all grievances, UM activities, and concerns for the DCBS population are routed to the DCBS lead for management. This addresses the tracking and actions for individual DCBS members related to access to care and complaints and the like.</p> <p>CCKY provided a process for evaluating satisfaction of child members in foster care. This is a new process to be implemented so there are no data at present.</p> <p>However, the survey addresses satisfaction only - it does not address population-based measurement and analysis of utilization, access, complaints and grievances for the DCBS population.</p> <p><u>Care Coordination File Review</u> 10 files were reviewed. 8/10 included a comprehensive assessment and care plan; for the 2 remaining files – one opted out of care coordination and the other has no needs identified.</p>	<p>measurement year. Metrics will be applied identically to this population and the ISHCN population.</p> <p>The ISHCN population will be defined as the child and adolescent enrollees, in the SSI and Foster categories of aid, and those who received services from the Commission for Children with Special Health Care Needs (CCSHCN), who received the specified services related to access to care and preventive care, as defined in the HEDIS specifications.</p> <p>The outline of the measurement procedure/steps is attached as KY PM 2014 CSCHN_Access_Preventive_Care_Final_Rev_7-10-2014.docx.</p>



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			<p><u>Complex Case Management File Review</u> 10 of 10 files reviewed included a comprehensive assessment, care plan, identification of physical and behavioral health needs, and facilitation and coordination of services.</p> <p><b><u>Recommendation for CCKY</u></b> CCKY should track specific population-based measures for analysis and comparison to other populations. Stratifying measures across the member populations would satisfy this requirement. CCKY could examine the rates for the KY performance measures related to ISCHN (access to PCPs, well child visits, etc.) and implement actions for improvement where warranted. Other measures could include: utilization of ED, inpatient, primary care, dental and other services to identify potential gaps on a population-level.</p>	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.				
<b>35.1 Individuals with Special Health Care Needs (ISHCN)</b>				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical,				



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behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.				
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 physical health illnesses; and individuals with chronic behavioral health illnesses.				



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The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.				
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 practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.				
<b>35.2 DCBS Protection and Department for Aging and Independent Living DAIL Protection and Permanency Clients</b>				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded	<b>Minimal</b> - Addressed in P/P CM 017. Reports 65 and 66 provided. <u><a href="#">DCBS Service Plan File Review</a></u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these	Substantial	Addressed in P/P CM-017. CCKY submitted the following reports: 1. Foster Care active as of 1-29-14 with ME codes.xlsx 2. Care coordination listing 7-1-13 thru 12-31-13 with codes.xlsx	The plan will continue to communicate and meet with DCBS on a regular basis. Each month the plan attends the Liaison Meetings with delegates from DCBS, DMS, CRP, and MHNET to address concerns as illustrated below.  Dates of Liaison Meetings and agenda items



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<p>to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.</p>	<p>members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services.</p> <p>Regardless of provision of a service plan, files reviewed demonstrated ongoing care coordination, when appropriate.</p> <p><u>DCBS Claims File Review</u>  IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination files for selected members were requested.</p> <p>Twenty files were reviewed with the following results:</p>		<p>In the onsite interview, CCKY indicated that P/P FIN-001 Reporting Timeframes addresses monthly reporting of Foster Care Cases, specifically, Report #65 Foster Care and Report #66 Guardianship.</p> <p><u>DCBS Service Plan File Review</u>  IPRO conducted a review of DCBS Services Plans. A total of 12 files were reviewed.</p> <p>4 of 12 had no DCBS signature  9 of 12 had no MCO signature  1 of 12 cases demonstrated use of the service plan to identify the member's medical needs and need for CM.  10 of 12 cases demonstrated ongoing coordination of care with DCBS. There was documentation of many attempts by the CM to reach the DCBS worker.  1 of 12 cases had documentation of need for and referral to CM.  8 of 12 cases demonstrated monthly meeting of CM/DCBS to coordinate and address the needs of the child.</p> <p>CCKY indicated that it was difficult to reach the DCBS workers in many cases and that the MCO DCBS liaison has been aggressive in efforts to obtain service plans. This has been particularly challenging due to the large number of service areas/counties and DCBS offices. Often service plans are sent to CCKY</p>	<p>covered during the First Quarter 2014:</p> <ul style="list-style-type: none"> <li>• 01/23/2014(Telephonic)  In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet  Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues</li> <li>• 02/27/2014 (Telephonic):  In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet  Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues</li> <li>• 03/27/2014 (Telephonic):  In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet  Discussed: Foster Care Service Plans, Satisfaction Surveys, Barriers to Assisting Members, Discharge Planning and individual member issues</li> </ul>



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	<p>13 of 20 files included evidence of at least one well visit during the review period. Of the remaining 7 files, 4 files lacked evidence of a well visit and 3 files were not applicable (2 members were not due for a well visit and one member was hospitalized in a NICU).</p> <p>Of the 13 files including a well visit, provision of EPSDT services was evident in 12 files (one file - claims did not show evidence of an EPSDT service code).</p> <p>Outreach efforts were not evident in the 5 files lacking a well visit and/or EPSDT service claim.</p> <p>Care coordination was evident in 7 files reviewed. The remaining 13 files did not require care coordination services.</p> <p><b>MCO Response:</b> Please see Policy CM-017 which has been updated to reflect the process for obtaining services plans for DCBS and DAIL clients.</p>		<p>from DCBS, and therefore, there is no MCO signature on the Service Plan. CCKY provided meeting logs which evidenced regular meetings with DCBS.</p> <p>Files showed a lot of back and forth via voicemail for the MCO CM to reach the DCBS worker.</p> <p>The CM files were well-documented and showed evidence of ongoing identification of needs, referrals and linkage, care coordination, and follow-up where necessary.</p> <p><u>DCBS Claims File Review</u>  IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination. The files did not contain claims data. CCKY did provide this via ftp posting. Claims were reviewed offsite after the onsite review.</p> <p>Ten files were reviewed with the following results:  9 of 10 files included evidence of at least one well visit during the review period.  9 of 10 files evidenced EPSDT services provided.  1 of 1 file evidenced outreach for lack of</p>	<ul style="list-style-type: none"> <li>• 04/24/2014 (Face to Face):  In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet  Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues</li> <li>• 05/22/2014 (Face to Face):  In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet  Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues</li> <li>• June meeting was cancelled per the state.</li> </ul>



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	<p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, Coventry Cares requested DCBS schedule monthly meetings to discuss and sign off on service plans.</p> <p>Claim specific to EPSDT service code for one file was located in the Navigator system. Evidence is enclosed.</p> <p>EPSDT outreach includes reminders for needed EPSDT visits with the provider. The letters are automatically uploaded to the Navigator</p>		<p>EPSDT services. 3 of 3 files evidenced coordination of PH and BH services. 10 of 10 files showed coordination between providers and services.</p> <p>For the one member who did not have any well visits or EPSDT services, the CM noted a history of non-compliance and did conduct outreach for EPSDT services.</p> <p>Of note: CCKY has developed and is using an excellent tracking sheet which includes: Program Status, Category Code, medically fragile, date of contact initiation, number of attempts to contact DCBS, permission from DCBS to contact foster parent, screening tool completed, acute needs addressed, benefits questions addressed, referrals/resources provided, mailed information sent, therapies, need for coordination of therapies during school breaks, enrollment in First Steps or CM, member not enrolled in CM/case closed, member not enrolled in CM/follow-up call scheduled, ESPDT special services, reason member not enrolled in CM, conference calls, incoming calls from DCBS/foster parent.</p> <p><b><u>Recommendation for CCKY</u></b></p>	



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	system. See enclosed documentation for original dates of outreach.		CCKY should continue its efforts to obtain Service Plans and to meet with DMS and DCBS staff to establish effective information-sharing protocols.	
<b>35.3 Adult Guardianship Clients</b>				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.	<p><b>Non-Compliance</b> - P/P CM 017 indicates that individual in adult guardianship have separate policies, however these were not provided for review.</p> <p><b>MCO Response:</b> Policy CM-012 has been revised and is enclosed for review. The updated policy will be presented to the Policies &amp; Procedure Committee for review and approval.</p>	Full	Addressed in P/P CM-017 (Case Management of Persons with Special Needs) and CM-012 (Case Management for Adult Guardianship).	
<b>35.4 Children in Foster Care</b>				
Upon Enrollment with the Contractor, each child in Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the	<p><b>Minimal</b> - Addressed in P/P CM 011.</p> <p><u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has</p>	Substantial	Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs). As noted above, CCKY makes diligent efforts to obtain Service Plans for all foster children who are members. CCKY provided logs to demonstrate regular meetings with DCBS. See element 35.2 above for detailed information.	<p>The plan will continue to communicate and meet with DCBS on a regular basis. Each month the plan attends the Liaison Meetings with delegates from DCBS, DMS, CRP, and MHNET to address concerns as illustrated below.</p> <p>Dates of Liaison Meetings and agenda items covered during the First Quarter 2014:</p> <ul style="list-style-type: none"> <li>• 01/23/2014(Telephonic) In attendance: Representatives from the Department for Community Based</li> </ul>



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Contractor's Network.	<p>been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services. Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.</p> <p><b>MCO Response:</b> Please see Policy CM-017 which has been updated to reflect the process for obtaining service plans for DCBS and DAIL clients.</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests</p>		<p><u>DCBS Service Plan File Review</u> 4 of 12 had no DCBS signature 9 of 12 had no MCO signature 1 of 12 cases demonstrated use of the service plan to identify the member's medical needs and need for CM. See element 35.2 above for further detail.</p> <p><b>Recommendation for CCKY</b> CCKY should continue its efforts to obtain Service Plans and meet with and coordinate with DMS and DCBS staff.</p>	<p>Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues</p> <ul style="list-style-type: none"> <li>02/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues</li> <li>03/27/2014 (Telephonic): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Satisfaction Surveys, Barriers to Assisting Members, Discharge Planning and individual member issues</li> <li>04/24/2014 (Face to Face): In attendance: Representatives from the Department for Community Based</li> </ul>



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	<p>the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, CoventryCares requested DCBS schedule monthly meetings to discuss and sign off on service plans.</p>			<p>Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, Supports to Children with Complex Needs, Behavioral Health de-certifications, Individual Member issues</p> <ul style="list-style-type: none"> <li>• 05/22/2014 (Face to Face): In attendance: Representatives from the Department for Community Based Services, Department for Medicaid Services, Children's Review Program, CoventryCares of Kentucky and MHNet Discussed: Foster Care Service Plans, SSI de-certifications, Barriers to Assisting Members, Individual Member Issues</li> <li>• June meeting was cancelled per the state.</li> </ul>
<p>If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.</p>	<p>NA - Addressed in P/P CM 017 and CM 011.</p> <p><u>DCBS Service Plan File Review</u> None of the files reviewed required case management services.</p>	<p>Full</p>	<p>Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs).</p> <p><u>DCBS Service Plan File Review</u> Only one file evidenced the need for CM services and was referred for CM. See element 35.2 above for further detail.</p>	



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<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.</p>	<p>NA - Addressed in P/P CM 011.</p> <p><u>DCBS Service Plan File Review</u> None of the files reviewed required case management services.</p>	<p>Full</p>	<p>Addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services) and CM – 017 (Case Management of Persons with Special Needs).</p> <p><u>DCBS Service Plan File Review</u> The CM files were well-documented and showed evidence of ongoing identification of needs, referrals and linkage, care coordination, and follow-up where necessary.</p>	
<p>The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker.</p> <p>That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.</p>	<p><b>Minimal</b> - Addressed in P/P CM 011.</p> <p><u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical</p>	<p>Substantial</p>	<p>Partially addressed in P/P CM-011 (Case Management for Members in Foster Care and Members Receiving Adoption Services).</p> <p>P/P documents do not address cases where the DCBS and CM staff cannot reach an agreement on the service plan for a Member, i.e. that the case will be forwarded to the designated county DCBS worker, that the case might be referred to mediation or DMS for resolution.</p> <p>In the interview, CCKY indicated that P/P CM-011 would be updated to address situations where CCKY and DCBS cannot reach an agreement on the Service Plan/CM enrollment.</p> <p><u>DCBS Service Plan File Review</u></p>	<p>The following language has been added to CM-011 and sent for review to the Policy and Procedure Committee for approval:</p> <p>If the DCBS staff and the plans Foster Care/Subsidized Adoption Case Manager Liaison cannot reach agreement on the service plan for a member, information about that member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS staff and Foster Care/Subsidized Adoption Case Manager Liaison will be forwarded to the designated county DCBS worker.</p> <p>The DCBS staff member shall work with the plans Foster Care/Subsidized Adoption Case Manager Liaison and a designated Department</p>



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	<p>needs and to identify members for case management services.</p> <p>Coventry Cares should continue to work with DCBS to obtain timely, complete service plans and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.</p> <p><b>MCO Response:</b> Please see Policy CM-011 which has been updated to reflect the process for obtaining services plans for DCBS and DAIL clients.</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on</p>		<p>IPRO conducted a review of DCBS Services Plans. A total of 12 files were reviewed. 4 of 12 had no DCBS signature 9 of 12 had no MCO signature</p> <p>As indicated prior, CCKY has a designated DCBS liaison, is diligent in efforts to obtain Service Plans, and has arranged to meet regularly with DCBS staff.</p> <p>If a Service Plan is received in other than a DCBS/CCKY meeting, it will not have an MCO signature.</p> <p><b>Recommendation for CCKY</b> P/P CM-011 should be updated to address situations where CCKY and DCBS cannot reach an agreement on the Service Plan/CM enrollment.</p>	<p>representative, if needed, to agree on a service plan. If the agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.</p>



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	6/20/13. During the meeting, CoventryCares requested DCBS schedule monthly meetings to discuss and sign off on service plans.			
<b>35.5 Children Receiving Adoption Assistance</b>				
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.	<p><b>Minimal</b> - Addressed in P/P CM 017 and CM 011.</p> <p><u>DCBS Service Plan File Review</u> Coventry Cares reports ongoing efforts to obtain service plans for DCBS and DAIL clients and to coordinate care for these members. Receipt of service plans and ongoing communication with DCBS has been inconsistent and this inconsistency was noted in the files reviewed. Of 20 files reviewed, service plans were provided in 11 files. When service plans were provided, the MCO used the information to determine the member's medical needs and to identify members for case management services.</p> <p>Coventry Cares should continue to work with DCBS to obtain timely, complete service plans</p>	Full	<p>Addressed in P/P CM-017 and CM-011.</p> <p><u>DCBS Service Plan File Review</u> A total of 12 files were reviewed. There was a Service Plan for each file reviewed.</p>	



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	<p>and to establish regular communications (e.g., monthly meetings) to discuss the needs of individual DCBS members.</p> <p><b>MCO Response:</b> The Prior Authorization Request Form has been updated to request the actual IEP form. (Enclosed)</p> <p>The plan's Foster Care liaison began requesting missing service plans on 6-5-13 as part of each conversation with DCBS. When the DCBS liaison calls the plan with a foster care child or adoption services child issue, the plan Foster Care liaison requests the service plan. Calls from the DCBS liaison are typically those that are escalated to the plan for immediate resolution. These members are the ones who are mostly likely to have a completed service plan.</p> <p>A meeting with DCBS occurred on 6/20/13. During the meeting, Coventry Cares requested DCBS schedule monthly meetings to discuss and sign off on service plans.</p>			



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	See revised CM-011 and CM-017. (Enclosed)			
<b>32.9 Pediatric Sexual Abuse Examination</b>				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.				
<b>32.8 Pediatric Interface</b>				
<p>The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services.</p> <p>The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.</p>	<p><b>Substantial</b> - Addressed in P/P CM 017 although not explicit regarding coverage during interruptions.</p> <p><b><u>Recommendation for Coventry Cares</u></b>  P/P CM 017 should be revised to address coverage during interruptions.</p>	Full	<p>Addressed in P/P CM-017.</p> <p>CCKY has created a tracking tool in which receipt of First Steps and school-based services is documented. Additionally, the tracking tool indicates that continuity for school-based services will be needed during school breaks. The file(s) for which this was applicable evidenced efforts to maintain continuity of school-based services during school breaks.</p>	
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations	Substantial - Addressed in P/P CM 017 although not explicit regarding coverage/responsibilities during interruptions.	Full	<p>Addressed in P/P CM-017.</p> <p>The policy states: For pediatric members enrolled in case management and receiving school based services, the case manager will coordinate care for any interruptions in</p>	



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<p>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><b><u>Recommendation for Coventry Cares</u></b> P/P CM 017 should be revised to address coverage during interruptions.</p>		<p>school based services.</p>	
<p>The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.</p>				
<p>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.</p>	<p>Substantial - Addressed in P/P CM 017 although does not explicitly address parental permission.</p> <p><b><u>Recommendation for Coventry Cares</u></b> P/P CM 017 should be revised to address parental permission.</p>	<p>Full</p>	<p>Addressed in P/P CM-017.</p>	



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Services provided under HANDS shall be excluded from Contractor coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.				
<b>37.11 DCBS and DAIL Service Plans 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.				



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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	8	3	0	1
Total Points	24	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>2.73</b>		

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

**Reviewer Decision:**

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

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

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



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### Case Management/Care Coordination Suggested Evidence

#### Documents

Policies/Procedures for:

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

Case manager and care coordinator position descriptions

Evidence of dissemination of information to members, member representatives and providers relating to care management services

Evidence of monitoring effectiveness of case management

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

Evidence of dissemination of information and materials specific to the needs of the ISHCN member

Evidence of practice guidelines or other criteria considering the needs of ISHCN

#### Reports

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

Number of DCBS and DAIL clients enrolled in the MCO as of the last day of the review period (December 31, 2013)

Number of DCBS and DAIL clients enrolled in the MCO who are enrolled in case management/care coordination as of the last day of the review period (December 31, 2013)

Monthly reports of Foster Care cases



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#### **File Review**

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

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

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

DCBS Case Management files/claims records



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<b>22.6 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 these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Substantial - During the on-site visit, the MCO advised that the member's rights and responsibilities are located on the Website and are accessible to all out-of-network providers.  <b><u>Recommendation for Coventry Cares</u></b> The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.	Substantial	Member rights and responsibilities are included in the Provider Manual and are available on the MCO website. A policy/procedure for describing the MCO's method for communicating this information to out of network providers was not evident in the documents provided.  Onsite: CCKY noted that the provider manual is available on the MCO website to out of network providers.  <b><u>Recommendation for CCKY</u></b> The MCO should include in its policies/procedures the method for providing this policy to out-of network providers.	The contract language specifically requires CCKY to provide member rights and responsibilities policies to any Out-of-Network Provider <b>upon request</b> from the provider. Any requests received by a provider, by any means, including through the Provider Call Center, is provided to them and providers are referred to the MCO website where it is easily accessible.
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;				



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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. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;				
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;				
F. Timely access to care that does not have any communication or physical access barriers;				
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;				
H. Assistance with Medical Records in accordance with applicable federal and state laws;				
I. Timely referral and access to medically indicated specialty care; and				
J. 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;				



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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.				
<b>22.2 Member Handbook</b>				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.				
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.				
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.				
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.				



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The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:				
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;				
B. The procedures for selecting a PCP and scheduling an initial health appointment;				
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;				
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;				
E. Member rights and responsibilities including reporting suspected fraud and abuse;				
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;				
G. Procedures for obtaining transportation for both emergency and non-emergency situations;				



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H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;				
I. Procedures for arranging EPSDT for persons under the age of 21 years;				
J. Procedures for obtaining access to Long Term Care Services;				
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;				
L. A list of direct access services that may be accessed without the authorization of a PCP;				
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;				
N. Information about how to access care before a PCP is assigned or chosen;				
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;				
P. Procedures for obtaining Covered Services from non-network providers;				
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;				
R. Information about the Cabinet for Health and Family				



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Services' independent ombudsman program for Members;				
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;				
T. Information on the availability of health education services;				
U. Information deemed mandatory by the Department; and				
V. The availability of care coordination, case management and disease management provided by the Contractor.				
<b>30.3 Second Opinions</b>				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request for a second opinion.				
<b>22.1 Required Functions</b>				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Standard Time (EST). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has				



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separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.				
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).				
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.				
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and				



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Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.				
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.				
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	<p>Non-Compliance - Coventry Cares did not provide a policy and procedure for Member Services Functions. The MCO advised that the functions are listed in the training manual.</p> <p><b>MCO Response:</b> New Policy MC-016 Member Services Functions has been drafted. (Enclosed) It will be reviewed and approved by the Policies &amp; Procedures Committee.</p>	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b>Recommendation for CCKY</b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
B. Monitoring the selection and assignment process of	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed	As noted by the reviewer, CCKY submitted P/P MC-



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PCPs;			<p>in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	008 Member Services, dated 2/27/14 which addresses this requirement.
C. Identifying, investigating, and resolving Member Grievances about health care services;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
D. Assisting Members with filing formal Appeals regarding plan determinations;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016,</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which



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			<p>cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	addresses this requirement.
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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and abuse;			included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b>Recommendation for CCKY</b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
G. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b>Recommendation for CCKY</b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);			<p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	
I. Explaining or answering any questions regarding the Member Handbook;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;			After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
K. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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			<p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	
M. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening,	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;			submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
O. Facilitating access to behavioral health services and pharmaceutical services;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
P. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services,	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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			dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
Q. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.  <b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Non-Compliance – See above.	Non-Compliance	Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.  After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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			<p>requirement but is outside the timeframe.</p> <p><b>Recommendation for CCKY</b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	
S. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b>Recommendation for CCKY</b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
T. Facilitating access to Member Health Education Programs;	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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			<p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	
<p>U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in <b>Covered Services</b> upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and</p>	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p> <p><b><u>Recommendation for CCKY</u></b>            Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.
<p>V. The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.</p>	Non-Compliance – See above.	Non-Compliance	<p>Member Services functions not addressed in the documents provided. Policy MC-016, cited in last year's MCO response, was not included in the submitted documents.</p> <p>After follow-up with the MCO, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement but is outside the timeframe.</p>	As noted by the reviewer, CCKY submitted P/P MC-008 Member Services, dated 2/27/14 which addresses this requirement.



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			<b><u>Recommendation for CCKY</u></b> Policy/procedure should address member services functions as noted in the MCO's contract with DMS. The 2014 policy/procedure addresses the requirement.	
<b>30.4 Billing Members for Covered Services</b>				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.				
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.				
<b>22.9 Choice of Providers</b>				
Dual Eligible Members, Members who are presumptively				



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eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.				
The Contractor shall have two processes in place for Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.				
<b>23.4 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 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 Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.				
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member				



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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 or inability to meet the medical needs of the Member.				
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.				
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 make the change for request in writing. Member may request PCP change in writing, face to face or via telephone.				
The Contractor shall provide written notice within fifteen				



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(15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the Contractor's network.				
<b>30.5 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:**

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
Number of Elements	0	1	0	22
Total Points	0	2	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				.09

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

**Reviewer Decision:**

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

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



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**Documents**

Policies/Procedures for:

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

Member Handbook including any separate inserts or materials

Sample Member newsletters and other informational materials

Sample Provider newsletters and other informational materials

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

Sample of member notifications of voluntary and involuntary PCP termination

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

**Reports**

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

Annual Member Services Report

Call center metrics

Medical call-in system metrics



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<b>Medical Records</b> <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<b>38.1 Medical Records</b>				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.				
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.				
The Contractor shall include provisions in its Subcontracts for access to the Medical	Substantial - P/P UM – 031 Clinical Record Confidentiality addresses confidentiality.	Full	This requirement is addressed in the Provider Manual. When a member changes	



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<p>Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.</p>	<p>The following contracts address this requirement:  VSP- Section 7.5 Medical Records  Access to Records – Section 7.6  Inspection and Audits of Records Section 7.4</p> <p>Medco - Section 9 Pharmacy Records  Transition Period  Records – Section 6</p> <p>Avesis-Section 9 Medical Records  Transfer of Medical Records  Access to Records and Audits, Number 4</p> <p>ASH-Section 2.18 &amp; Section 9  Business Associate Agreement – Number 8</p> <p>NIA-Medical Records Section 7  Access to Records, Section 8</p> <p>MHNet-Access to Medical Records - Section IV  Access to Medical Records for Inspection – Section IV  Access to Records  Transfer of Records – Article III, Section 3.3.</p> <p><b><u>Recommendation for Coventry Cares</u></b>  The contracts should include a provision for when a member changes PCPs, e.g., the medical records or copies of medical records shall be forwarded to the new PCP within ten (10) Days from receipt of request and the Contractor's PCPs shall have members sign a release of medical records before a</p>		<p>their PCP; the previous PCP will forward, at no cost to the plan or member, the member's medical records within 10 days of request to the member's new PCP.</p> <p>The transfer of medical records to a new PCP is addressed in the Provider Manual under Records Management.</p>	



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	medical record transfer occurs.			
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.				
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:				
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;				
B. Allow for the tracking and trending of individual and plan wide provider performance over time;				
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care				



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concerns; and				
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.	<p>Non-Compliance - Evidence of a process for detecting instances of over-utilization, under-utilization, and miss utilization was not provided.</p> <p><b>MCO Response:</b> Please see policy UM-017 enclosed and the Program Integrity Plan. Both documents address monitoring over and under utilization of services.</p>	Full	The following document addresses this requirement: UM - 017 Monitoring of over under utilization.	
<b>27.6 Medical Records</b>				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Member's Medical Record is the				



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property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).				
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:				
A. Member/patient identification information, on each page;				
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship				



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information;				
C. Date of data entry and date of encounter;				
D. Provider identification by name;				
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;				
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);				
G. Identification of current problems;				
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;				
I. Documentation of immunizations pursuant to 902 KAR 2:060;				
J. Identification and history of nicotine, alcohol use or substance abuse;				
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department				



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for Public Health pursuant to 902 KAR 2:020;				
L. Follow-up visits provided secondary to reports of emergency room care;				
M. Hospital discharge summaries;				
N. Advanced Medical Directives, for adults;				
O. All written denials of service and the reason for the denial; and				
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.				
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;	<p>Substantial - The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool states "identification of current problems, significant illnesses, and medical/psychological condition</p>	Substantial	<p>The Provider Manual states that the CCKY Providers are responsible for maintaining records according to the state and federal requirements. Specifically it is addressed in the section on Medical Record Documentation Standards.</p> <p>As noted last year, the medical record documentation audit tool states "identification of current problems, significant illnesses, and medical/psychological condition should be</p>	<p>The medical record documentation audit for 2014 has been completed. The medical documentation tool will be updated to reflect this change and will be implemented to capture the physical examination requirements outlined for this recommendation- to be effective for the 2015 audit.</p>



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	<p>should be indicated on the Problem List/or progress note." Physical examination is not included in the tool.</p> <p><b><u>Recommendation for Coventry Cares</u></b>            Audit tool for medical record documentation should include all required elements.</p>		<p>indicated on the Problem List/or progress note." Physical examination is not included in the tool.</p> <p><b><u>Recommendation for CCKY</u></b>            Provider Manual, audit tool and guidelines in P/P #QI-015 (Medical Record Documentation Review) should be consistent and include all required elements in the contract.</p>	
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and				
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.	<p>Substantial - The Provider Manual states that the Coventry Care Providers are responsible for maintaining records according to the state and federal requirements.</p> <p>The MCO's Medical Records Documentation Review – Fax Blast detailed the medical chart organization and documentation requirements.</p> <p>The medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen. Follow-up plans are addressed.</p>	Substantial	<p>This is addressed in the Provider Manual in the section on Medical Record Documentation Standards.</p> <p>As noted last year, the medical record documentation audit tool includes medication history but does not address medications prescribed, including the strength, amount, directions for use and refills; or therapies and other prescribed regimen. Follow-up plans are addressed.</p> <p><b><u>Recommendation for CCKY</u></b>            Provider Manual, audit tool and guidelines in P/P #QI-015 (Medical Record Documentation Review) should be</p>	<p>The medical record documentation audit for 2014 has been completed. The medical documentation tool will be updated to reflect this change and will be implemented to capture the medication requirements outlined for this recommendation-to be effective for the 2015 audit.</p>



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	<b><u>Recommendation for Coventry Cares</u></b> Audit tool for medical record documentation should include all required elements.		consistent and include all required elements in the contract.	
<b>27.7 Advance Medical Directives</b>				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.				
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.				
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical				



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appointment and chart that discussion in the medical record of the Member.				
<b>38.2 Confidentiality of Records</b>				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.				
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.				



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The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.				
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.				
<b>40.12 Health Insurance Portability and Accountability Act</b>				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the subcontractor be required to abide by the same statutes and regulations regarding				



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confidentiality of protected health information as is the Contractor.				



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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	2	2	0	0
Total Points	6	4	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>2.5</b>		

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

**Reviewer Decision:**

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

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

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



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#### Suggested Evidence

##### Documents

Policies/procedures for:

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

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

Member materials related to Advance Directives

Provider materials related to Advance Directives

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

##### Reports

Provider compliance assessment/monitoring results and follow-up



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<b>33.3 General Behavioral Health Requirements</b>				
The Department requires the Contractor's provision of mental health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.				
<b>33.4 Covered Behavioral Health Services</b>				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.				
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV.				
Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.				
<b>33.5 Behavioral Health Provider Network</b>				
The Contractor must emphasize utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to				



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assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.				
The Contractor shall utilize DSM-IV classification for Behavioral Health billings.				
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.				
In order to meet the provider network requirement for BH services, Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.	<p>Substantial - Demonstrated in Geo Access reports.</p> <p>Coventry Cares provided Geo Access reports for July 2012 for Community Mental Health Centers. All counties were compliant with the exception of:</p> <p>Region 5, Madison at 65.9% for urban Region 6, Gallatin and Grant at 66.2% and 86.2% for urban.</p> <p><b><u>Recommendation for Coventry Cares</u></b> The above counties did not meet access standards. This may be due to the number of CMHCs available for contracting in those counties. The MCO should clarify whether all CMHCs in the region were offered participation and whether all accepted participation.</p>	Substantial	<p>Addressed in Geo Access reports.</p> <p>All counties were compliant with the exception of:</p> <p>1 Provider within 30 miles Fulton County, 55.8% for urban Livingston County, 96.9% for urban Meade County, 90.5% for urban</p> <p>1 Provider within 30 minutes Henderson County 99.6% for urban Ballard County 92.4% for urban Fulton County 50.2% for urban Hancock County 40.8% for urban Henderson County 99.6% for urban Livingston County 87.4% for urban Meade County, 79.4% for urban Trigg County, 99.6% for urban Breckinridge County, 96.8% for rural</p> <p>CCKY clarified that 100% of CMHCs had been offered network participation and</p>	100% of the CMHCs in the Commonwealth of Kentucky are participating providers with MHNet and have been since go live on Nov. 1. 2011. All available CMHC's are being utilized. CCKY will continue to recruit providers and will continue to comply with the requirements of the Geo Access reporting.



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			<p>all accepted.</p> <p>In the interview, CCKY/MHNet acknowledged that there are some gaps in some counties. The MCO added that starting in 2014, any licensed provider, e.g., psychologists, may participate in the BH network and this will help with access. CCKY/MHNet stated that 156 providers had been added to the network.</p> <p><b><u>Recommendation for CCKY</u></b> CCKY/MHNet should continue to recruit providers and re-assess the Geo-Access.</p>	
Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.				
The Contractor shall ensure accessibility and availability of qualified providers to all Members in the service area pursuant to Provider Program Capacity Demonstration as contained in the RFP. When necessary to meet the access standards for Behavioral Health Services for its Members, the Contractor may include in its provider network other specialty care clinic providers with comparable core services of the CMHC's.	<p><b>Minimal</b> - Program capacity demonstrated in Geo Access reports. The MCO also provided a listing of credentialed behavioral health providers.</p> <p>Coventry Cares provided the MHNet Quality and Utilization Management Fourth Quarter Report dated 1/31/13 including monitoring results for provider appointment availability. The results presented include MHNet's national provider network; results for the individual Kentucky market are not available.</p>	Substantial	<p>Addressed in Geo Access reports. As noted above, access is expected to improve due to the opening of the network to additional types of BH providers.</p> <p>Accessibility is addressed in these reports; however, provider availability is not measured. In the interview, CCKY/MHNet indicated that appointment availability surveys for the Kentucky market had been initiated and provided the telephone script.</p>	Starting in January 2014, CCKY began monthly surveys of the Kentucky providers. This survey addresses appointment availability, and seeks to confirm address/phone, specialties/ages served and languages spoken. This information is reported monthly on KY Report 118.



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	<b>MCO Response:</b> MHNet is currently in compliance with this standard. MHNet has offered network participation to all CMHCs in KY and currently contracts with 100% of the CMHCs. Please see enclosed document for supporting information.		<b>Recommendation for CCKY</b> CCKY/MHNet should evaluate the results of the availability survey when available and take action where necessary.	
To the extent that non-psychiatrists and other providers of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.				
Since the Contractors shall offer participation agreements to the Community Mental Health Centers to participate in their Behavioral Health network, should a Community Mental Health Center decline participation in the Contractor in that service area, or if the Contractor fails to meet access or any other terms and conditions of the contract the Contractor may meet its BH network requirements by offering participation to other qualified specialty care clinic providers with comparable core CMHC services.				
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.				
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-				



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network Providers with relevant experience.				
<b>33.6 Behavioral Health Services Hotline</b>				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Contractor's region.				
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.				
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.				
It is not acceptable for an intake line to be answered by an answering machine.				
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:				
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;				
B. No incoming calls receive a busy signal;				
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting				



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an option;				
D. The call abandonment rate is seven percent (7%) or less;				
E. The average hold time is two (2) minutes or less; and				
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.				
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.				
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	<p><b>Minimal</b> - The document provided – Member Services Manual 5 does not address duration of calls. Other documents referenced – UM Manual 3.5 and Customer Service Monitoring Tool were not provided.</p> <p><b>MCO Response:</b> Both the Member Services Manual and the Utilization Management Policy &amp; Procedures were updated to reflect MHNet's current policy that there is no call limit. We have never had a limitation on call duration. Please see enclosed documentation.</p>	Full	Addressed in updated Member Services Manual 5 (page 3).	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.				
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is				



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knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.				
The Contractor shall conduct on-going quality assurance to ensure these standards are met.				
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.				
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
<b>33.7 Coordination between the Behavioral Health Provider and the PCP</b>				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.				
The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements	Substantial - The Provider Orientation Education policy and procedure, and Provider Orientation Presentation provided do not explicitly address screening and identification of behavioral health	Full	Addressed in PCP Newsletter 2013.	



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for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.	disorders.  <b><u>Recommendation for Coventry Cares</u></b> Provider training should address screening and identification of behavioral health disorders.			
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.	Full - Addressed in the MHNNet UM Manual and Provider Quick Reference Guide.  <b><u>Recommendation for DMS</u></b> It is suggested that future annual compliance reviews include a behavioral health/physical health file review to assess coordination of physical health and behavioral health services, and compliance with behavioral health standards.  <b>DMS Response:</b> DMS agrees with IPRO's recommendation. Appropriate files will be requested from each MCO for the next compliance review.	Substantial	Addressed in MHNNet UM Manual, Provider Quick Reference Guide and PCP Newsletter 2013.  CCKY has in place a strong PH/BH mutual referral system with specific forms to be completed.  <b><u>BH/PH Care Coordination File Review</u></b> 10 files were reviewed 2 of 5 files evidenced a comprehensive assessment with the required components 2 of 5 files evidenced a care plan with the required components 4 of 9 files evidenced identification of the PH and BH needs of the member and facilitation and coordination of needed services 0 of 8 files evidenced follow-up/rescheduling of missed appointments 0 of 5 files for hospitalized members evidenced participation in discharge planning 0 of 10 files evidenced information sharing, other than the initial referrals	Based upon CCKY's prior relationship as separate companies, MHNNet has no access to the medical side of members' records, and Health Services staff has no access to Behavioral Health. During any audit or chart review, MHNNet will ensure to pull records of members who have had coordinated care (through the standard Coordination of Care process) so that CCKY can evidence our coordinated services to those members with comorbid BH and medical conditions. CCKY is currently in the process of integrating BH and Health Services to provide a holistic care model for members. Until this is fully integrated, the corresponding medical health records will need to be requested from Health Services by the reviewer to accurately reflect coordination efforts.



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			<p>from/to BH CM.</p> <p>Note the following:            Assessment - Many members were unable to contact, however, some information was available from the PH referral form. The 2 assessments that were present were narrative/informal assessments but were very detailed.            Care Plan - Many members were unable to contact. The 2 care plans that were present were narrative and informal but communicated a clear plan for the member as far as referrals and resources.            Identify and Address Needs - The referral forms from PH to MHNet often contained background information on the member's PH and BH condition(s) as well as needs. As noted above, where a care plan was present, a clear plan was communicated.            Missed appointments rescheduled – scheduled appointments were evident in many of the records in the notes or an authorization letter in the file. However, there was no documentation of follow-up to determine if the member kept the appointment.            Discharge Planning - For the members who had an inpatient MH stay, participation in discharge planning was not seen in the files. In one case there is</p>	



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			<p>a notation of a "30 day plan" but details are not included.</p> <p>Information Sharing - Many cases ended after one outreach attempt with UTC and a letter sent or CM spoke with member with no further documented outreach conducted.</p> <p>It is important to note that in the interview, CCKY/MHNet indicated that the 30 day plan is a discharge plan for inpatient follow-up for the first 30 days post-discharge and was not included in the files for review. A sample was provided onsite.</p> <p>MHNet P/P Utilization Improvement Manual regarding discharge planning and follow-up were provided by CCKY/MHNet onsite.</p> <p>P/P Chapter 6 Discharge Planning and Follow-up includes (section 6.1) initiating discharge planning, arranging follow-up care, and documentation; (section 6.2) contact after discharge, assessment/provision of resources, procedure for UTC: at least 2 phone attempts, letter, and follow-up in 10 days with an additional phone attempt as well as sending an appointment reminder letter on discharge, contact with the provider(s) to confirm that the</p>	



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			<p>appointment was kept, and procedure for rescheduling and/or other follow-up if the appointment is not kept.</p> <p>P/P Chapter 4 National Service Center Utilization Improvement which states that when a CM makes a referral to a provider, the CM will contact the provider to ensure that an appointment can be made, ask the provider to call if the member does not keep the appointment, and follow-up for authorization of continued treatment where necessary.</p> <p>P/P Chapter 5 Managing Ongoing Care provides the procedure for initiating BH CM. This includes at least 2 phone attempts at different hours of the day, mailed letter, call attempt 10 days after the letter, and efforts to obtain alternate member contact information from providers, PH CM, and the MCO.</p> <p>The sample 30-day plan provided was an Intensive Care Management Plan for a member with an inpatient stay that included the assessment, care plan, follow-up plans/appointments, and follow-up contacts with member and providers.</p> <p>Note: A possible QOC issue was identified in</p>	



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			<p>the file review:</p> <p>The female member had been inpatient for suicidal ideation. The referral form had a notation of the member communicating that her PCP had refused to see her and she had been unable to fill her antidepressant prescription for 2 months prior to her admission. In response, the CM notes indicated that she needs a new PCP and has problems getting meds due to lock-in status.</p> <p>It was not clear if the member got a PCP reassignment or if she was able to obtain her medications, or if the difficulties getting her depression meds were resolved.</p> <p>Also, the claim that the PCP refused to see the member and she could not get her medications was not directly addressed despite that fact that the member complained she had subsequent suicidal ideation and was admitted to an inpatient facility. The member's reliability could not be determined from the case documentation, but in any case, this should have been investigated and confirmed or referred as a potential QOC issue. Note that the member may have had a 30 day plan that was not available for review onsite.</p>	



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			<p>In the interview, the case was discussed with the MCO and CCKY indicated that the issue would be investigated. To date, no additional information has been received.</p> <p><b>Recommendation for CCKY</b> CCKY/MHNet should address the following:</p> <ul style="list-style-type: none"> <li>- Ensure that more than one outreach attempt is made for members referred for BH issues.</li> <li>- Ensure that when members are referred for outpatient treatment and/or appointments are scheduled, that follow-up is conducted to ensure that the member keeps the appointment.</li> <li>- For future file reviews, ensure that all documentation, from both PH and BH, is provided for review.</li> </ul>	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.				
The Contractor shall require that behavioral health				



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Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.				
<b>33.8 Follow-up after Hospitalization for Behavioral Health Services</b>				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.				
The outpatient treatment must occur within fourteen (14) days from the date of discharge.				
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	<p><b>Minimal</b> - The MHNNet UM Manual 6 indicates that case managers will contact members who have missed appointments; however a timeframe for doing so is not included in the policy.</p> <p><b>MCO Response:</b> This is documented in the attached Provider Contract (Section 27) and the Provider Addendum. We have modified the Provider Quick Reference Guide to reflect this. See enclosed documents.</p>	Substantial	<p>Provider Quick Reference Guide (page 15) indicates a procedure must be in place to contact members who missed their appointments; however a timeframe is not indicated.</p> <p><b>Recommendation for CCKY</b> CCKY/MHNNet should add the 24 hour timeframe to the Provider Quick Reference Guide.</p>	CCKY has sent a request to marketing to update the Provider Quick Reference Guide to reflect the 24 hour timeframe. CCKY is currently awaiting a timeline for completion.
<b>33.9 Court-Ordered Services</b>				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				



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The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.				
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Substantial - The Provider Quick Reference Guide does not address modification or termination of services.  <b><u>Recommendation for Coventry Cares</u></b> Policy should be expanded to include modification or termination of services.	Full	The Provider Quick Reference Guide, Kentucky Medicaid Addendum, (page 32) addresses the CCKY/MHNet policy for coverage of court-ordered commitment for members under the age of twenty-one (21) or over the age of sixty-five (65) according to KY regulations.	
<b>33.10 Community Mental Health Center (CMHC)</b>				
The Contractor shall coordinate with the Community Mental Health Center (CMHC) or other qualified special health care providers, other providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric hospital.				
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include				



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responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.				
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide case management services to Members with severe mental illness and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.				
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.				
Appropriate follow up by the Behavioral Health Service provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.				
The Contractor shall ensure the Behavioral Health Service				



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Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.				
<b>33.11 Program and Standards</b>				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);				
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	<p><b>Minimal</b> - Documents provided discuss coordination of care and sharing of information. MHNNet Provider Quick Reference Guide references coordination of medication usage. Documents for non-behavioral health providers, such as the Provider Manual and physician contract do not specifically address sharing of medication usage information.</p> <p><b>MCO Response:</b> MHNNet has a process in place to address polypharmacy issues through the pharmacy department. MHNNet facilitates coordination of information between PCPs and Behavioral health Providers. Please see enclosed documentation.</p>	Full	<p>Addressed in Pharmacy Anti-Fraud, Waste and Abuse Guide (page 2) and MHNNet Provider Quick Reference Guide (page 15). The Reference Guide makes note of the need to share information with the PCP, especially when the member is on medication.</p> <p>CCKY/MHNNet also provided copies of provider newsletters prepared for PCPs (8/2013) and BH practitioners and facilities (5/2013) which addressed coordination of care, including BH medications.</p> <p>During the interview, CCKY/MHNNet</p>	



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	<p>MHNet facilitates communication between Primary Care Physicians and Behavioral Health Providers. Members are requested to give permission for MHNet to provide copies of their outpatient treatment plan request (OTR) to their primary care physician. The OTR is submitted by the behavioral health provider to request additional authorization for treatment. It includes current diagnosis, clinical information, risk factors and medications. This treatment plan is usually received and forwarded by MHNet every three to six months. Behavioral health providers and primary care physicians are encouraged to communicate in addition to this program to ensure members' needs are met.</p> <p>Members receive the consent form to allow MHNet to send clinical information to their PCP at the time they first access services in the member brochure. There continues to be the barrier that members may be hesitant to share behavioral health information with their PCP. MHNet in partnership with the health plans will educate members and providers about the importance and positive outcomes of coordinated care.</p> <p>MHNet routinely completes treatment record review to ensure that quality care is being provided to members and documented. As part of this process MHNet monitors to ensure that behavioral health and primary care providers are communicating to provide coordinated services</p>		<p>described the process used to address polypharmacy issues. This is accomplished through the pharmacy department's Drug Utilization Review (DUR) program. CCKY/MHNet provided documentation, including the list of drug edits by class and specific drug name(s) which are monitored via hard edits.</p> <p>CCKY/MHNet also coordinates sharing the Outpatient Treatment Plan with the PCP with member consent.</p> <p>CCKY/MHNet indicated that there are barriers due to members' not consenting. The Provider Quick Reference Guide encourages BH providers to educate members regarding the importance of sharing information and the potential dangers of not sharing information.</p>	



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



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**Scoring Grid:**

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

**Overall Compliance Determination:**

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

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

**Reviewer Decision:**

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

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

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



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### Behavioral Health Services Suggested Evidence

#### Documents

Policies/procedures for:

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

Benefit Summary (covered/non-covered BH services)

Provider Manual

Sample PCP contract

Sample BH provider contract

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

Process for monitoring compliance with hotline requirements

Process for educating PCPs of BH services/requirements

Evidence of training of PCPs regarding BH services/requirements

Sample participation agreement with CMHCs

Sample collaborative agreement with state operated or state contracted psychiatric hospitals

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

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

Process for facilitating the exchange of pharmaceutical information among providers

Process for evaluating continuity and coordination of care among providers

QI Plan



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

**Reports**

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