



KY EQRO ANNUAL REVIEW

March 2014

Period of Review: January 1, 2013 – December 31, 2013

MCO: Passport Health Plan

Final Report 9/22/2014

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
19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full-PHP's 2012 Quality Improvement (QI) Program Description outlines the plan's comprehensive program that addresses clinical quality, member safety, member satisfaction, care coordination and access and services issues.	Full	This requirement is addressed in PHP's 2013 Quality Improvement (QI) Program Description, which describes the plan's comprehensive infrastructure for the continuous monitoring, evaluation and improvement in care, safety, and service. Evidence for ongoing assessment, monitoring and evaluation is reflected in the QI Work Plans and Program Evaluation.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Full-The QI Program Description describes activities including evaluation of access (utilization including EPSDT, prospective practitioner site visits, access reports, member grievances), continuity of care (case management/disease management activities, medical record audits, member grievances), health care outcomes (HEDIS and Healthy Kentuckian measures, Clinical Practice Guideline audits, Performance Improvement	Full	This is addressed in PHP's 2013 QI Program Description, which includes activities such as: conducting medical record reviews against documentation standards and Continuity and Coordination of Care standards; assessing provider/practitioner access and availability and reviewing member complaints regarding access; conducting Performance Improvement Projects (PIPs), calculation of HEDIS and Healthy Kentuckian performance measures, monitoring over and under-utilization, and monitoring and evaluating for improvements to physical health outcomes resulting from behavioral health integration into the member's overall care.	



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	Projects, monitoring of sentinel events and member grievances) and other plan services (delegation oversight activities, provider satisfaction, service measures).			
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full-PHP's QI processes include prospective, concurrent and retrospective quality improvement activities that are outlined in the QI Program Description, UM Program Description and Clinical Programs Program Descriptions; the QI structure is clearly defined in the Program Description.	Full	This requirement is addressed in the 2013 QI Program Description, which outlines a structured and organized set of activities and processes related to quality of care and includes: objectives, goals, scope, identified barriers, and planned activities that address the quality and safety of clinical care and quality of services. Also included are provisions for developing and implementing systematic data collection methodologies and developing planned and ongoing quality initiatives. These structures and processes are reflected in the QI Work Plans.	
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.	Substantial-The QI Workplan was updated (p.57) to include EQR findings, and indicates how the issues that were identified were addressed.	Full	The 2013 QI evaluation has been updated to include a section on the External Quality Review Organization's (EQRO) Annual Evaluation. In conjunction with the EQRO, PHP Quality Program evaluation and activities include linkage of activities and processes across departments, with objectives that include continuously	



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	<p>Recommendation for PHP Include in the QI evaluation any system changes identified via the plan's PIPs. PIP reports should include a description of any system changes that were made and whether they were sustained.</p> <p>MCO Response: Passport accepts the recommendation and will update the 2012 QI Evaluation to include any system changes identified via Passport's PIPs. PHP will also update the 2013 PIP reports to include a description of any system changes that were made and denote mechanisms that ensure sustainability of success.</p>		<p>monitoring and analyzing clinical, safety and service indicators. Opportunities for improvement identified in QI activities and reported in the Program Evaluation are reflected in the QI Work Plan. System changes implemented as a result of PIPs are described in the QI Evaluation and PIP reports.</p>	
<p>The QAPI program shall be developed in collaboration with input from Members.</p>	<p>Full-The Quality Member Access Committee (QMAC) meets every two months.</p> <p>The Partnership Council</p>	<p>Full</p>	<p>The Quality Member Access Committee (QMAC) meets every two months and must meet at least four times per year. Ongoing oversight of program deliverables has been delegated to the Partnership</p>	



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	membership, as per the 2012 QI Program Description, includes consumer advocates or members, and consumer advocates are represented on the Quality Medical Management Committee (QMMC); these bodies approve the annual QI Program and Evaluation and QI Work Plans.		Council, which includes member advocates. Member advocates are also represented on the Quality Medical Management Committee (QMMC). QMAC minutes demonstrate active participation of members in discussion of QI activities, including review of the Program Description.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full-QMAC bi-monthly reports provided. QMAC Committee minutes document evidence of member input; Committee minutes reveal review of QI Work Plans, discussion of Case and Disease Management Programs, discussion of care management for special needs populations, medical record audits, clinical practice guidelines, member concerns, and access and availability.	Full	The QMAC is charged with accountability for the review of member complaints for quality of care and sentinel events having the potential for an adverse effect on members and as referred to the QMMC by plan staff. The QMMC reviews aggregate data of member complaints, transfers, surveys, as well as the results of provider audits, and makes determinations regarding corrective action to be taken. QMMC and QMAC minutes were provided and include discussion of member-related issues and performance improvement activities.	



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The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	Full-The plan has held NCQA accreditation with "Excellent" status for its Medicaid product line from September 16, 2008-September 16, 2012. Reaccreditation will extend to September 30, 2014, with Excellent status.	Full	The plan has held NCQA accreditation with "Excellent" status for its Medicaid product line from September 16, 2008-September 16, 2012. Reaccreditation will extend to September 30, 2014, with Excellent status.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	Full-Copy of 2011 certification status provided, which extends to September 30, 2014.	Full	Addressed -Copy of 2011 certification status provided, which extends to September 30, 2014	
Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.	Full-An email dated 1/30/12 was sent by PHP to DMS.	Full	The plan provided attestation of timely submission of the QAPI Program Description.	
As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.	New Requirement	Full	The 2013 QI Program Description outlines the goal to provide support to monitor and evaluate the quality of health care on an ongoing basis, such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care and behavioral health are studied and	



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			<p>prioritized for performance measurement, monitoring and evaluating for improvements to physical health outcomes resulting from behavioral health integration into the member's overall care, performance improvement and/or development of practice guidelines.</p> <p>Onsite staff indicated that behavioral health indicator monitoring was just beginning (HEDIS Antidepressant Medication Management, ADHD, schizophrenia measures). The plan noted that Beacon, the behavioral health vendor, reports behavioral health measures. The plan provided evidence of PIPs focused on behavioral health and innovative programs that include a psychotropic drug program. As per the QI Program Evaluation, the plan is collaborating with Beacon on a project focused on members with diabetes and depression, which includes screening members with diabetes for depression and counseling for those at risk. The plan is also collaborating with Beacon to address pregnant women with behavioral health issues.</p>	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the	New Requirement	Full	PHP collects and reports several HEDIS behavioral health measures, including Antidepressant Medication Management,	



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member's overall care.			ADHD and the Schizophrenia measures as well as CAHPs questions on behavioral health care. Interventions based on the findings of these measures included efforts to improve the integration of behavioral and physical health. As noted above, the plan is collaborating with Beacon to address pregnant women with behavioral health issues and depression screening for members with diabetes.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful	Full-EQRO recommendations and plan responses were included in the Annual QI Program Evaluation. PHP addressed several of the EQRO recommendations and indicated it is implementing interventions to address the recommendations. As an example, a section in the QI Evaluation is devoted to the recommendations made by the EQRO in the 2012 Compliance Review and includes how PHP will address the recommendations. Also,	Full	This requirement is addressed in the 2013 Program Evaluation, which includes a comprehensive evaluation program and includes step taken to address issues raised by the EQRO. The plan provided attestation that the evaluation was submitted by July 31.	



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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>PHP added an analysis of inpatient utilization by Category of Aid to the Program Evaluation.</p> <p>The QI Program Evaluation also assesses the effectiveness of the QI Program, and includes identification of barriers to improvement and changes to the program to be implemented, which are included in subsequent Work Plans.</p>			
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	<p>Full-PHP provides information to the EQRO for mandatory and optional activities, including documentation for the annual review, performance measure reports, Performance Improvement Project (PIP) reports and samples for focused studies conducted by the EQRO.</p> <p>Documentation for the</p>	Full	<p>Providing information to the EQRO is included in the QI Program Evaluation. The EQRO is provided with information needed to fulfill the mandatory and optional activities, including documentation related to performance improvement projects, performance measures and information needed for the focused studies.</p> <p>Documentation for the compliance review was provided to the EQRO by 2/28/14.</p>	



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	annual compliance review was provided to the EQRO by 2/28/12.			
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.	New Requirement	Full	This requirement is addressed as reflected in the plan's submitted documents. The EQRO's recommendations have been incorporated into PHP's Program Description and Program Evaluation and the various committees are provided with the results of the EQRO's recommendations. Interventions to improve quality of care have been designed centering on the EQRO's recommendations.	
21.4 EQR Administrative Reviews				
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 the Contractor.	Full-The Provider Manual (page 2), was updated to include reference to the role of the EQRO. A letter from PHP to its providers was provided as an example. The letter informed providers of an upcoming ADHD study to be conducted by DMS and IPRO and asked them to cooperate by providing medical records for data	Full	The plan has provided provider and member information for EQR activities, including focused studies, validation studies, and annual compliance review. The Provider Manual explains the role of the EQRO.	



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	collection.			
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	New Requirement	Full	PHP has cooperated with the EQRO in providing the EQRO with files/samples to conduct focused studies, in responding to issues addressed in connection with performance improvement projects and in providing necessary documentation to conduct the compliance reviews. The plan has also submitted performance measure documentation for validation as requested.	
21.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	New Requirement	Full	In conjunction with the EQRO, PHP Quality Program evaluation and activities include linkage of activities and processes across departments, with objectives that include continuously monitoring and analyzing clinical, safety and service indicators. In addition, PHP participated in calls with DMS and EQRO during the review period to discuss selected health outcome measures as appropriate. Also, select health outcomes measures are chosen for monitoring care in collaboration with DMS and the EQRO.	



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			<p>New or revised measures that are clinically sound and consistent with Healthy Kentuckians goals, and that complement the plans' quality improvement goals, are discussed collaboratively with DMS, EQRO, and the MCOs.</p> <p>PHP responded to compliance review findings and there is evidence of incorporation of recommendations from 2013 review into documentation and processes in the submission of responses to findings and Corrective Action Plans.</p>	
<p>A. Assign a staff person(s) to conduct follow-up concerning review findings;</p>	<p>Full-Several PHP staff is assigned to address review findings.</p> <p>The 2012 QI Program Description identifies the Director of Quality Improvement as the person responsible for implementing the QI Program, which includes reviewing and responding to recommendations from the external review.</p>	<p>Full</p>	<p>The documentation of follow-up activities for review findings from prior review was submitted by the Compliance Director. The Director of Quality Improvement is the person responsible for implementing the QI Program. The Manager of Quality Improvement oversees the day-to-day operations of the Quality Improvement Department. Additionally, there are seven QI staff members who perform the QI Department responsibilities.</p>	
<p>B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the</p>	<p>Full-The 2011 Program Evaluation was updated to</p>	<p>Full</p>	<p>The 2012 QI Program Evaluation, which was completed in 2013 when data were</p>	



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committee in the development, implementation and monitoring of the corrective action plan; and	include the statement that "EQRO findings should be presented to quality committees and included in the QI Program Evaluation."		available, and the 2013 work plan were updated with the EQRO's recommendations and were submitted to the appropriate committees for approval as evidenced in committee minutes.	
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.	Full-PHP submitted a timely response to review findings, including updating policies and implementation of new activities and procedures. Several documents were updated during the onsite review, as a result of the EQRO reviewer's recommendations.	Full	The plan submitted a corrective action plan for EQR findings within 60 days and resolved issues within six months as documented in EQR response and CAP submission letters. An action plan based on EQRO findings is noted in the Program Evaluation.	
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full-EQRO findings are included in the QI Program Description as an objective and in the Program Evaluation as the responsibility of the Quality Department. Monitoring of member complaints and grievances has been added to the 2012 Work Plan.	Full	The EQRO findings are included in the QI Program Description and in the Program Evaluation, and initiatives incorporating the findings are described in the 2013 QI Work Plan. The Work Plan was updated based on EQRO recommendations.	



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E. If contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	NA-No evidence of disagreement.	Not Applicable	NA-No evidence of disagreement.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that	Full-PHP provided the 2011 Work Plan, which is updated quarterly. The 2011 QI Program Evaluation was approved by the Quality Medical Management Committee, the Partnership Council, and the UHC Board in the 1 st quarter, 2012.	Full	The 2013 Work Plan was provided. The QI Work Plan includes objectives, goals, scope, identified barriers, and planned activities that address the quality and safety of clinical care and quality of services.	
outlines the scope of activities and	Full-The Work Plan outlines the scope of activities for each area of concentration organized by focus areas that include safety, member and provider satisfaction, delegation oversight, continuity and coordination, access and availability, credentialing, medical management, special populations and the quality improvement program.	Full	The QI Program description describes the Work Plan and states that it includes the scope of activities. A review of the 2013 Work Plan indicates that the scope of each activity is included.	
the goals,	Full-The Work Plans include program goals for the	Full	Addressed -- The Work Plan includes program goals for the activities, which are	



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	identified area of focus.		quantifiable.	
objectives, and	Full-Objectives are included in each of the focus areas of the Work Plan.	Full	Objectives are included in each of the focus areas of the Work Plan. <u>Recommendation for PHP</u> The objective for each activity is stated but, it would be helpful if it were labeled as such to make it easier to identify.	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by updating the 2 nd Qtr 2014 Workplan document, and going forward, Goals and Objectives are clearly marked. Passport has submitted a one page screen shot noting the change. 
timelines for the QAPI program.	Quality improvement activities are reported quarterly, and include time frames of completion of activities. <u>Recommendation for PHP</u> Though activities are noted by Quarter in the Work Plan, the timeliness for implementing current and future activities is not included. PHP may want to consider including an annual	Full	Quality improvement activities are reported quarterly, and time frames of completion of activities are included in the Work Plan. Although the plan did not submit an annual Executive Summary for review for this period, 2013 Work Plan goals include target dates and the status of activities are updated quarterly as noted above.	



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	<p>"Executive Summary" in the Work Plan highlighting key milestones as well as the dates that the milestones were achieved.</p> <p>MCO Response: Passport Health Plan accepts the recommendation and will compile an annual "Executive Summary" of the 2012 Work Plan to highlight key milestones as well as the dates that the milestones were achieved. The "Executive Summary" will be submitted to the appropriate Quality committees for review and approval.</p>			
<p>New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.</p>	<p>Full-Opportunities for improvement noted in the review of quality activities and studies are incorporated into goals in the Work Plans, which are updated quarterly; Work Plan goals and objectives are updated annually.</p>	<p>Full</p>	<p>Work Plan activities, goals, barriers, interventions and measurement, are updated quarterly based on performance and barriers noted as evidenced by the submitted 2013 QI Work Plan.</p> <p>A section regarding EQRO recommendations and activities is included in the Work Plan.</p>	



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	In response to the prior year EQRO recommendation, recommendations were added to the Work Plan.			
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full-The UHC board is the governing body for the plan as noted in QI Program Description; UHC delegates ongoing oversight of deliverables for the QI and UM programs to the Partnership Council, and the Quality Medical Management Committee (QMMC) provides direction to and oversight of the provision of clinical care and services.	Full	The QI Program is submitted to the Quality Medical Management Committee, the Partnership Council, and the UHC Board for review and approval. The UHC Board has authority and responsibility for the quality of care delivered under the product Passport Health Plan. The Quality Medical Management Committee (QMMC) and Director of Quality have the responsibility for planning, designing, implementing and coordinating the patient care and clinical quality improvement activities as delegated by the Partnership Council.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full-UHC delegates ongoing oversight of deliverables for the QI and UM programs to the Partnership Council, and the QMMC provides direction to and oversight of the provision of clinical care and services. The Chief Medical Officer	Full	Ongoing oversight of program deliverables has been delegated to the Partnership Council. The Quality Medical Management Committee (QMMC) and Director of Quality have the responsibility for planning, designing, implementing and coordinating the patient care and clinical quality improvement activities as delegated by the Partnership Council.	



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	provides day to day oversight of quality improvement and credentialing activities.		QMMC and Partnership Council minutes reflect approval of the QAPI Program Description, Evaluation, and QI Work Plan.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full-Partnership Council minutes reflect review of the surveys, and case management and disease management programs, and review of QMMC committee minutes. The QMMC has been delegated the responsibility of review and approval of the annual QI and UM Program Descriptions and Evaluations, review of the QI Work Plan and review and feedback of audit findings and clinical and preventive health guidelines.	Full	The QMMC provides recommendations regarding provider education and interventions, health education programs, and other plan initiatives. QMMC committee meeting minutes indicate recommendations to accept the Program Description and quarterly work plans and include a review of survey results. Both QMMC and Partnership Council minutes reflect review of QI and UM Program Evaluations, medical record audits, guideline compliance and other reports.	
review on an annual basis of the QAPI program; and	Full-The 2011 Annual QI Program Evaluation Report provides the infrastructure for the continuous monitoring, evaluation and improvement in care,	Full	The QI Program Evaluation discusses the structure of the organization throughout 2012. The Evaluation considers the network management activities and the plan's credentialing and recredentialing activities, and the clinical and service	



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	safety, and service. The report includes a discussion of the network management activities, credentialing and recredentialing activities, clinical and service activities, and an overall assessment of effectiveness and opportunities for 2012.		activities. It concludes with an overall assessment of effectiveness and opportunities for 2013. The QI Program Evaluation was reviewed by the QMMC and Partnership Council as per meeting minutes.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full-The Partnership Council committee minutes reflect ongoing discussion of QI activities. The QI Program Evaluation report monitors and analyzes key clinical and service indicators and intervention studies in clinical and service areas which were selected based on review of data.	Full	The Program Evaluation states that an objective of the QI Program is to continuously monitor and analyze key clinical and service indicators. QMMC and Partnership Council meeting minutes reveal discussion of findings of quality improvement initiatives. The 2013 QI Work Plan includes updates to interventions based on barriers and concerns noted, as well as interventions to address review findings.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Full-The QMMC is responsible for direction and oversight of clinical care and services, and reports every two months to the Partnership Council; it met 9	Full	The QMMC provides direction to, and oversight of, management and subcommittee functions responsible for the provision of clinical care and services. The QMMC is responsible for approval of	



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	times in 2012 to meet QI program objectives. Committee minutes reflect robust participation and discussion of quality activities and results.		the annual QI and UM Program descriptions, twice annual review of the QI Work Plan and Annual QI and UM Evaluations.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Full-The QMMC includes provider and administrative staff members, as well as pharmacist, medical ethicist, member advocate and health department representation; committee representatives include a neonatologist and a pediatrician. The Women's Health Committee is scheduled to meet quarterly beginning in 2013. Plan has been experiencing difficulty in attracting members to attend. The March 2013 agenda was provided onsite.	Full	The QMMC is composed of a Clinical Pharmacist, PHP's Chief Medical Officer, the Medical Director, a Health Department representative, and practitioner representatives from the following disciplines: Internal Medicine, Pediatrics, OBGYN and Chiropractic's, other quality, provider relations and UM PHP staff, a Medical Ethicist and a Consumer Advocate. The plan has had difficulty recruiting members for the Women's Health Committee, which met only once in the review period. The plan has OB representation on the QMMC. Recommendation for PHP The plan should continue efforts to recruit members for the Women's health Committee.	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by currently investigating the potential of adding a Medical Director to the staff specifically trained as an OB/GYN. One of the objectives for the Medical Director will be to engage his/her peers in active participation in Passport's Women Health Initiatives in order to improve the health and quality of life of female Kentuckians.



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<p>The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.</p>	<p>Full-The QMMC must meet at least 8 times per year, and committee minutes document nine QMMC meeting during the review period; participation and discussion are very active; the plan provides committee minutes to DMS in quarterly reports.</p>	<p>Substantial</p>	<p>The QMMC meets monthly and must meet at least eight times during the year to meet QI Program objectives. Committee minutes were available for each meeting, and QMMC minutes indicate that discussion is active and member concerns are addressed. The QMMC met monthly during the review period; however, there was no quorum for 5 of the meetings, including those taking place from July through October of the review period (1/8/13, 7/2/13, 8/6/13, 9/10/13, and 10/1/13). FAX votes were obtained when there was no established quorum.</p> <p>Recommendation for PHP The plan should ensure that QMMC meets regularly with the intended interdisciplinary structure.</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation by currently reviewing all of its Quality Committees to be sure we include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs, as well as to cover all geographical areas of our Commonwealth.</p>
<p>QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.</p>	<p>Full-Delegation oversight reports, which include quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the Delegation Oversight and QMMC committees.</p> <p>Quality and data submission</p>	<p>Full</p>	<p>PHP's Delegation Oversight Manual stipulates that the delegate clearly define its quality improvement (QI) goals, structures and objectives and its quality improvement program.</p> <p>Delegation oversight reports, which include quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the Delegation Oversight and</p>	



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	<p>information is included in the Provider Manual, and QAPI activity requirements; encounter record submissions are included in contracts and employment agreements.</p> <p>QI Work Plans and committee minutes include discussion of and provision of feedback for subcontractor QI activities; delegation oversight of subcontractor QAPI activities is included in the QI Program Evaluation.</p>		<p>QMMC committees.</p> <p>Encounter files must be reported weekly by the delegates.</p> <p>The Provider Manual provides for internal monitoring and auditing of provider and subcontractors and if issues are found, contractors must provide corrective action taken. Contractors must correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.</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-Delegation oversight reports, which include quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the Delegation Oversight and QMMC committees. Quality and data submission information is included in the Provider Manual, and</p>	<p>Full</p>	<p>The Program Description states that quality improvement activities are coordinated with other performance monitoring activities and management functions including, but not limited to utilization management, case and disease management, health management, risk management, patient safety, cultural and linguistic competency, credentialing, claims, member and provider services, and network development.</p>	



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	<p>QAPI activity requirements; encounter record submissions are included in contracts and employment agreements.</p> <p>QI Work Plans and committee minutes include discussion of and provision of feedback for subcontractor QI activities; delegation oversight of subcontractor QAPI activities is included in the QI Program Evaluation.</p> <p>The QI Program Description states that Quality Improvement activities are coordinated with other performance monitoring activities and management functions including, but not limited to utilization management, case and disease management, health management, risk management, patient safety, cultural and linguistic competency, credentialing,</p>		<p>Member Services, UM and Grievances and Appeals and other reports are reflected in QMMC meeting minutes.</p> <p>Delegation oversight findings, which include audit scores, interventions and quality improvement activities, are incorporated into the QI Program Evaluation and Work Plans, and are discussed in the Delegation Oversight and QMMC committees.</p>	



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	claims, member and provider services, and network development.			
<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 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>Full-The QI Work Plans and QI Program Evaluation provide evidence of staffing levels sufficient for comprehensive quality improvement activities.</p> <p>Departments throughout the plan participate in QI activities and collaborate across departments, including Member Services, Provider Relations and medical management.</p> <p>The Sentinel Events and Member Concerns Activity Summary document tracked sentinel events for 2012. In 2012, 146 sentinel events were referred to Quality for follow-up.</p>	Full	<p>The Chief Medical Officer (CMO) has been appointed by University Health Care to support the quality improvement committees outlined in this program by providing day-to-day oversight of quality improvement and credentialing activities. The CMO staff also includes two medical directors and one pharmacy director who each participate in and advise regarding implementation of the QI Program.</p> <p>The Director of Quality Improvement has been granted approval by the CEO of University Health Care to implement the QI Program. The Manager of Quality Improvement oversees the day-to-day operations of the Quality Improvement Department. Additionally, there are seven QI staff members who perform the QI Department responsibilities.</p> <p>The 2013 Work Plan includes staff responsible for each activity.</p>	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an	Full-The 2011 QI Program Evaluation and QI Work	Full	The 2013 QI Program Evaluation and the 2013 QI Work Plan contain evidence of	



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<p>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>Plans contain evidence of ongoing monitoring and evaluation of clinical care quality, including trending of standardized quality indicators (HEDIS measures, Healthy Kentuckian measures), special needs population case management/disease management metrics, utilization metrics and trending of sentinel events and member concerns. HEDIS measures are used to identify adherence to guidelines as well as over- and under-utilization and access.</p> <p>PHP's HEDIS auditor did not indicate any corrective action plans or note any concerns in their HEDIS Final Audit Report for 2012.</p>		<p>ongoing monitoring and evaluation of clinical care quality, including trending of standardized quality indicators (HEDIS measures, Healthy Kentuckian measures), case management/disease management metrics, utilization metrics and trending of sentinel events and member concerns.</p> <p>HEDIS measures are used to identify adherence to guidelines as well as over- and under-utilization and access.</p> <p>PHP's HEDIS auditor indicated that PHP was fully compliant with all NCQA-defined IS Standards for HEDIS-applied data and processes.</p> <p>The plan has begun reporting HEDIS behavioral health measures, including ADHD, follow-up of mental health hospitalization, Antidepressant Medication Management, and the schizophrenia and bipolar screening measures.</p>	
<p>B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.</p>	<p>Full-PHP performs ongoing monitoring of adherence to clinical practice guidelines using HEDIS measures and medical record review; the</p>	<p>Full</p>	<p>One of the plan's QJ Program objectives is to perform a quality review of key clinical and service indicators to assess and improve member and practitioner satisfaction. These clinical and service</p>	



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	<p>plan provided reports of audits of provider compliance with clinical practice guidelines using HEDIS measures (coronary/vascular conditions, hypertension and diabetes) as well as other medical record review (perinatal care).</p>		<p>indicators include reviews of:</p> <ul style="list-style-type: none"> • Member and provider complaints for care or service. • Sentinel events defined as any event involving member care that warrants further investigation for quality of care concerns. • National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®). • Application of current clinical guidelines. Clinical guidelines (Section 15 of the Provider Manual) • Application of medical record documentation and continuity and coordination of care standards. <p>According to the 2012 Program Evaluation, at the time of medical record review in support of HEDIS®, medical records are reviewed annually to assess practitioner compliance with adopted clinical practice guideline standards. For measurement year 2011, medical records were assessed for the following: Coronary/Vascular Clinical Practical Guidelines (CPG), Diabetes CPG, Hypertension CPG and Perinatal Care CPG. CPG compliance audits for measurement year 2012 for these</p>	



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			<p>guidelines are documented in the 2013 CPG Compliance Results document that was submitted by the plan.</p> <p>Partnership Council and QMMC meeting minutes reveal discussion of CPG. CPG audit reports are also reported and reviewed in the QMMC, including how to improve performance.</p>	
<p>Areas identified for improvement shall be tracked and corrective actions taken as indicated.</p>	<p>Full-Results are tracked and trended, and reports are generated for each clinical practice guideline.</p> <p>Results are reported in the 2011 QI Program Evaluation, and opportunities identified.</p>	<p>Full</p>	<p>The 2013 Program Evaluation presents results of practitioner compliance with the Clinical Practice Guidelines and barriers. Interventions to address them are identified.</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-Providers are re-evaluated after corrective action, and the audit schedule is documented in the QI Work Plan.</p>	<p>Full</p>	<p>The Provider Manual describes PHP's Program Integrity Plan that requires monitoring and auditing of its contractors and its subcontractors. If issues are found contractors must provide corrective action taken.</p> <p>According to the Provider Manual, practitioners must achieve an average score of 80% or higher on medical record review. PHP will monitor practitioners' scoring less than 80% through corrective</p>	



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			<p>action plans and re-evaluation.</p> <p>Provider audit findings and actions are reported in the QI Work Plan.</p>	
<p>C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.</p>	<p>Full-Multiple departments participate in QI activities, and staff from various departments is represented on the QMMC, including the Pharmacy Director, UM, Medical Management, Clinical Programs, and Member Services; the QMMC also includes representation from a range of provider disciplines.</p>	<p>Full</p>	<p>Several committees composed of members from multiple disciplines meet regularly -- QMMC, QMAC, the Partnership Council -- to discuss issues related to patient care and satisfaction, provider-related issues and internal systems. Multiple departments participate in plan QI activities.</p>	
<p>D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.</p>	<p>Full-PHP submits PIP documentation and other quality and performance improvement documentation to DMS upon request, including documentation submitted in quarterly reports and ad hoc requests for documentation are discussed during QI Work Group meetings.</p>	<p>Full</p>	<p>PHP submitted two PIP proposals: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP).</p> <p>The proposals were submitted in August, 2013, and updated and re-submitted on December 2013. The plan also submitted reports of ongoing PIPs, including Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and</p>	



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	PHP completed PIP reports for four projects it conducted in 2011-2012.		Upper Respiratory Infections (Antibiotics PIP), Dental Care in Children with Special Health Care Needs (Dental PIP), Reduction of Emergency Room Care Rates (Emergency Room PIP), and Smoking Cessation: Yes You Can! (Smoking Cessation PIP).	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Full-Clinical practice guidelines (CPG) are reviewed and approved by the Quality Medical Management Committee (QMMC) and distributed to affected plan practitioners. Once guidelines have been approved, they are reviewed and updated at a minimum of every two years or earlier based on when national standards are published and updated. Annually, Quality Improvement (QI) monitors practitioner performance against at least four clinical practice guidelines and identifies opportunities for health plan wide quality	Full	<p>The Program Evaluation describes PHP's efforts to develop and maintain Clinical Practice Guidelines (CPGs), which are reviewed and approved by the QMMC. The plan's goal is to adopt, maintain, and implement clinical practice guidelines that support clinical management of acute and chronic conditions relevant to PHP's membership.</p> <p>Eleven Clinical Practice Guidelines were approved by QMMC during 2012. Clinical Practice Guidelines updates were made on the PHP website and in the Provider Manual. The plan submitted a document entitled "CPGs Approved in 2013" as well; these CPGs are on the provider website. There were fourteen Clinical Practice Guidelines reviewed and approved or recommended for approval in 2013. QMMC minutes include discussion of CPGs</p>	



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	improvement activities.		including Preventive Services, Anxiety and Major Depressive Disorder.	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;	Full-PHP's Clinical Practice Guidelines are systematically developed descriptive tools or nationally recognized standardized specifications for care that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.	Full	According to PHP's Provider Manual, PHP makes every effort to ensure that current scientific data and expert opinion are the basis for each guideline. Each guideline is evaluated as new data becomes available or at a minimum of every two years. PHP monitors provider compliance and member outcomes related to these clinical guidelines for quality improvement initiatives and re-credentialing efforts. In the document entitled "CPGs Approved in 2013", PHP specifies each CPG, its objective, source and relevance. The cited sources are evidence based or consensus of health professionals.	
consider the needs of Members;	Full-Guidelines are relevant to the needs of members, and are updated and expanded as documented in the review period.	Full	According to the Provider Manual, the intent of the guidelines is to support efforts in the care and education of members and to reduce variation in diagnosis and treatment. Guidelines are relevant to the needs of members, and QMMC and PCP Workgroup minutes reveal discussion of CPGs. As per onsite staff, population diagnoses, hospital	



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			readmissions and other data are reviewed to ensure the needs of members are considered in development of CPGs. An approval schedule and target for implementation is designated for each approved CPG.	
developed or adopted in consultation with contracting health professionals, and	Full-All clinical guidelines are approved through QMMC and the Partnership Council before adoption by the plan. There is evidence of review of guidelines by providers in the plan's PCP Workgroup minutes, as well as in QMMC minutes.	Full	CPGs are approved by the QMMC and Partnership Council, which contain practitioners from a variety of disciplines. PCP Workgroup minutes reveal extensive discussion of CPG.	
reviewed and updated periodically.	Full-All CPGs adopted by the health plan are reviewed upon receipt of new scientific evidence or national standards, or at a minimum of every two years. 1. New scientific evidence may be identified through updated National Guidelines.	Full	Each guideline is evaluated as new data becomes available or at a minimum of every two years. The plan provided CPGs approved in 2012 and 2013.	



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	2. As updated, sources utilized for CPG adoption and revisions are reviewed for changes relevant to the adopted guideline.			
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.	<p>Full-P/P UM 35 defines the processes utilized to evaluate a proposed treatment plan, appropriate location, level of care, and duration of service as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.</p> <p>The QI Program Evaluation states that PHP adopts, maintains, and implements clinical practice guidelines that support clinical management of acute and chronic conditions relevant to the Plan's membership.</p>	Full	<p>P/P UM35 defines the processes utilized to evaluate a proposed treatment plan, appropriate location, level of care, and duration of service as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. A decision on which medical necessity is determined is based upon the application of recognized clinical criteria and internal medical policies.</p> <p>The Program Evaluation states that the purpose of the CPGs are to adopt, maintain, and implement preventive health guidelines that support ongoing early detection of illness and disease for the plan's membership.</p> <p>Member education, such as member newsletters provided by the plan, and care management programs are consistent with CPGs.</p>	



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19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.	New Requirement	Full	<p>PHP has developed a tracking document ("innovate Program XLS") describing its innovative programs. The document includes such programs as: Pre-term Labor Prevention, Smoking Cessation and Pediatric Obesity. Also described are several innovative program initiatives related to the pharmacy program: telemedicine, ePrescribing, Medical Therapy Management (MTM), polypharmacy and increasing the usage of generic drugs. Program components and status are included in the report.</p> <p>Recommendation for PHP It would be helpful if the tracking document included dates of implementation, the rationale/justification for the program and the approving committee. The document includes the "responsible party" but by name only. The department responsible for the program is not specified.</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation by changing the program we use to document our Projects/Innovative Programs from the Excel spreadsheet to PIPE. PIPE stands for Project Intake, Prioritization & Evaluation. This process is more detailed than our previous documentation and includes a business case to be submitted to a PIPE Committee and to be approved at the Director level prior to moving to the Executive Leadership Team for final approval. The Business Case includes key topics including proposed project, submitter, strategic alignment, problem statement, project justification, project deliverables, organizational impact, cost benefit analysis, timeline, stakeholder analysis, resource requirements, and risk assessment. This business case is presented to the PIPE Committee and voted on using set criteria and scoring methodology. Once a project is approved, it is prioritized based on its score and the submitter enters into the online PIPE tool available on OurSpace. The submitter is responsible for weekly updates to the tool. The tool gives the viewer a high level overview of each project and the ability to click on an individual project for more detail. Included are several documents/screenshots.</p>



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				 1-Business Case.docx  Project Management Pr...  PPIE Committee Charter.pdf  PPIE screenshots.docx  PHP-31.pdf
20.1 Kentucky Outcomes Measures and HEDIS Measures		Full		
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	New Requirement	Full	PHP has prepared a document (2012 Health Outcomes and 2013 Member Satisfaction) highlighting its performance measure results. The document includes a description of the measure, trended performance and interventions to improve. Also included are goals for four measures. Onsite staff indicated that goals for measures are at the 90 th percentile.	Passport Response: Passport appreciates the recommendation by IPRO and will take it under advisement.



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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.			Recommendation for PHP PHP may want to consider adding goals for the other measures or perhaps a global goal.	
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.	New Requirement	Not Applicable	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.	Full-A performance measure specific to individuals with special health care needs (Children and Adolescents) was developed and initiated during the review period in collaboration with DMS and the EQRO.	Full	PHP reports four Healthy Kentuckian measures (state-specific): Height/Weight and BMI Assessment for Children and Adolescents, Height/Weight and BMI Assessment for Adults, Adolescent Screening/Counseling and Cholesterol Screening for Adults. Performance is trended over time and interventions for each measure have been identified to enhance performance. In addition, a performance measure specific to individuals with special health care needs (Children and Adolescents) has been developed and initiated.	
The Department shall assess the Contractor's achievement of performance improvement related to the	Full-For reporting year 2010, the plan	Full	PHP met or exceeded the 2012 Quality Compass® 90th Percentile in nearly all sub-	



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<p>health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.</p>	<p>demonstrated improvement for most Healthy Kentuckian measures.</p> <p>For reporting year 2012, PHP was above the national Medicaid mean for the Adult BMI measure as well as for the Timeliness of Prenatal Care and Postpartum Care measures.</p>		<p>measures of Childhood Immunizations Status.</p> <p>24 HEDIS measures increased by four percentage points or more, of which, 14 measures exceeds the 2012 Quality Compass® mean.</p> <p>For the Healthy Kentuckian measures: PHP reported an increase in several measures in measurement year 2012.</p> <p>For the Child and Adolescent measures, PHP demonstrated an increase in:</p> <ul style="list-style-type: none"> -Documented Height/Weight -Healthy weight for Height -Nutrition Assessment/Counseling -Physical Activity Assessment/Counseling. <p>BMI Percentile/Value decreased.</p> <p>For the Adolescent Screening measure, Mental Health Assessment/Counseling increased while Tobacco, Alcohol and Substance Abuse and Sexual Activity decreased.</p> <p>All of the Adult-related measures showed an increase from 2011 to 2012: Height/Weight, BMI Percentile/Value, and</p>	



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			<p>Healthy Weight for Height, Nutritional Assessment/Counseling, Physical Activity Assessment/Counseling and Cholesterol Screening.</p> <p>The BMI and Adolescent measures that decreased are reflected in the 2013 QI Work Plan.</p>	
<p>Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.</p>	<p>Substantial-Performance measure rates, trending and identified barriers are documented in the 2011 QI Program Evaluation, and activities relevant to the measures are evident in the QI Work Plan, which is updated quarterly and submitted in quarterly reports. Performance measures were submitted in an annual report for 2010 and 2011.</p> <p><u>Recommendation for PHP</u> PHP should consider including quantifiable goals more consistently in the QI Work Plan, e.g., a goal for "Decreasing Preterm</p>	<p>Substantial</p>	<p>Measures tracked and reported in the QI Program Evaluation have associated goals, most of which are quantifiable. Activities on performance measures are included in the QI Work Plan.</p> <p>The Performance Measure Healthy Kentuckian report includes goals for 4 measures. Onsite staff indicated that the Work Plan will be updated to include goals for all measures.</p> <p>Evidence of stratification of measures by eligibility, race, ethnicity and gender was not provided in pre-onsite documentation, but onsite staff demonstrated that these data are available. The plan did not report measures by demographic subgroups.</p> <p><u>Recommendation for PHP</u> The plan should evaluate and report performance measures by eligibility, race,</p>	<p>Passport Health Plan Response: Passport Health Plan respectfully disagrees with the Substantial finding and requests this element be re-reviewed for consideration of a Full Compliance finding.</p> <p>Passport completes the Report #96 Audited HEDIS- which includes the NCQA Final Audit Report, the IDSS, Historical Trending and the Stratification of key HEDIS measures. This report is due August 31 of each year. Passport is actively using the stratification breakdown to determine interventions aimed at improving HEDIS rates. The document is shared with the QI team, department leads for each measure, and the HEDIS workgroup. This year the stratification data will be added to the discussion factors during the HEDIS 2015 Brainstorming/Planning session.</p> <p><u>Final Review Determination:</u> No change in compliance level.</p> <p>This review element relates to the Healthy Kentuckians Performance Measures, which include, but are not limited to HEDIS measures. In addition, the report of stratified HEDIS</p>



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	<p>Deliveries".</p> <p>MCO Response: Passport Health Plan accepts the recommendation and updated the 2013 QI Work plan to include quantifiable goals. While Passport continues to assess its results against the Quality Compass® Mean, the Quality Compass® 90th Percentile benchmark is used as the ultimate goal for HEDIS® performance measures.</p>		<p>ethnicity and gender as feasible with available data to monitor disparities in care.</p>	<p>results (#96) was not provided with the pre-site documentation or in conjunction with the onsite review. Additionally, based on the information provided on page 38 of this report, under 20.2 HEDIS Performance Measures, Passport Health Plan did not include the stratified rates in its submission of Report #96 to DMS.</p> <p>Passport Health Plan should evaluate and report the stratified results of the Healthy Kentuckians Performance Measures and proceed to set goals for each of these measures.</p>
20.2 HEDIS Performance Measures				
<p>The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.</p>	<p>Full-PHP provided the HEDIS Final Audit Report and Supplemental Audit Report dated July 2012 for review. The Final Audit Report and Review Table demonstrated that all measures within PHP's audit scope were reportable.</p> <p>DMS received submission of the Final Auditor's Report</p>	Full	<p>PHP provided the HEDIS Final Audit Report, prepared by their HEDIS Licensed Audit Organization. All measures within the scope of the audit were deemed to be reportable.</p> <p>The plan provided attestation of submission of the Final Audit Report (FAR) and IDSS to the Department.</p>	

Comment [SP1]: Pre-site or pre-onsite?



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	and IDSS by August 31.			
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.	New Requirement	Full	The Performance Measure Healthy Kentuckian report trends measures over three years. Benchmark data and goals for four measures are provided.	
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.	New Requirement	Minimal	<p>Evidence of stratification of measures by eligibility, race, ethnicity and gender was not provided in pre-on-site documentation, but onsite staff demonstrated that these data are available. The plan did not report measures by demographic subgroups.</p> <p>Recommendation for PHP The plan should evaluate and report performance measures by eligibility, race, ethnicity and gender as feasible with available data to monitor disparities in care.</p>	<p>Passport Response This is a required DMS Report # 96 which is an Annual Report due August 31st of each year. It was discovered in review of this finding, that the actual report was completed but not attached to last year's report. Passport has attached it for your review.</p> <div style="text-align: center;">  Report_96_HEDIS2013_byCategory.xlsx </div> <p><u>Final Review Determination:</u> No change in compliance level.</p> <p>As noted by Passport Health Plan, the stratified HEDIS results were unintentionally omitted from the submission of Report</p>



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				#96 to DMS and were not submitted with the compliance review documentation.
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.	New Requirement	Not Applicable	The plan reported all HEDIS measures with results as reported above; the plan onsite staff did not report being required to implement a PIP. To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	
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.	New Requirement	Not Applicable	To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results	New Requirement	Full	A copy of the NCQA certificate and accreditation report was submitted. The plan provided an attestation that documentation was submitted to the Department.	



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Recommendations and History to the Department in accordance with timelines established by the Department.				
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.	New Requirement	Not Applicable	PHP is NCQA accredited with "Excellent" status through 9/14.	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed.	New Requirement	Full	Two 2013 PIP proposals were submitted: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP). Ongoing PIPs for which reports were submitted in the review period include: Reduction of Inappropriately Prescribed Antibiotics in Children with Pharyngitis and Upper Respiratory Infections (Antibiotics PIP, proposal Aug 2012), Dental Care in Children with Special Health Care Needs (Dental PIP, proposal 9/1/2010), Reduction of Emergency Room Care Rates (Emergency Room PIP, proposal September 2011) and Smoking Cessation: Yes You Can! (Smoking Cessation PIP), for which a follow-up analysis was submitted.	



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			The PIP topics are selected based on prevalence, high risk, high utilization and member need as documented in the PIP proposal rationales.	
<p>The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a 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</p>	<p>Full-During the review period, PHP was engaged in the conduct of PIPs addressing Emergency Room Utilization, Reduction of inappropriately Used Antibiotics, Dental Care for Children with Special Health Care Needs, Smoking Cessation and Childhood Obesity.</p> <p>The chosen PIP topics address clinical areas relevant to the plan population, including the prevention of chronic conditions; the PIPs address access as well as clinical care, and in the Dental Care PIP the needs of a subpopulation based on eligibility category; culturally competent services are addressed in</p>	Full	<p>Two PIP proposals were submitted: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP), and there were several ongoing PIPs as documented above.</p> <p>The Performance Measure Healthy Kentuckian report demonstrates PHP's efforts to monitor its performance using HEDIS and state-specific measures. Interventions are included.</p>	



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competency of services, and complaints, grievances, and appeals.	some of the PIP interventions, as are non-clinical aspects of care such as access. PHP reports HEDIS annually and evaluates rates in the QI Work Plan.			
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full-PHP evidenced collaboration with local entities in its PIP on improving Dental Care Access where it participated in five community events. For its PIP on Reducing Emergency Department utilization, PHP collaborated with two hospitals. The Work Plan notes participation in community events. PHP includes a Health Department representative on the QMMC.	Full	A Health Department representative sits on the QMMC, and health departments and community organizations are represented on the Partnership Council. The QI Work Plan notes outreach and participation in community events and collaboration with community organizations. The PIP proposal for the Psychotropic Drug Intervention Program indicates that the plan will collaborate with Beacon Health's Psychotropic Drug Intervention Program.	
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	Full-PHP participates with DMS and the EQRO in monthly QI workgroup	Full	PHP participated in teleconference calls with DMS, the MCOs and the EQRO during the review period to evaluate	



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practices and use of encounter data-driven performance measures.	meetings, during which quality activities and development and revision of performance measures are discussed; progress on PHP's PIPs is an agenda item for each discussion.		opportunities and interventions. This includes, but is not limited to, discussion of monitoring and ensuring continued improvement for HEDIS measures and Healthy Kentuckian measures. The plan participates in focused studies and PIP discussions with the Department and EQRO.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to behavioral health. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department may require Contractor to (i) implement an additional PIP specific to the Contractor; if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.	Full-PHP is currently conducting four PIPs. Reports for each of the four PIPs were completed and submitted on 8/31/12.	Full	Two PIP proposals were submitted for 2013: You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP). As noted above, there were several ongoing PIPs as well: the Antibiotics PIP (proposal August 2012), Dental PIP (proposal 9/1/2010), Emergency Room PIP (proposal September 2011) and Smoking Cessation PIP. Each PIP presents a rationale for the topic selection that includes prevalent and high risk/high utilization conditions, need for coordination, and/or preventable complications and utilization.	
The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of	New Requirement	Not Applicable	The plan is conducting PIPs as above, with topics approved by the Department.	



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Medicaid members in Appendix N.				
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:	New Requirement	Full	PHP is reporting PIPs using the template provided by the state.	
A. Topic and its importance to enrolled members;	New Requirement	Full	Each PIP proposal includes a discussion of the PIP topic and rationale, including its relevance to plan membership.	
B. Methodology for topic selection;	New Requirement	Full	Each PIP proposal includes a discussion of the PIP topic and how it was selected. For example, the ED PIP included analysis of plan data and performance, and the Dental PIP included a discussion of Healthy Kentuckian performance and the significance of this issue in Kentucky. PIPs are discussed in QMMC committee as evidenced by committee minutes.	
C. Goals;	New Requirement	Full	The plan's submitted PIP proposals include goals.	
D. Data sources/collection;	New Requirement	Full	Each submitted PIP proposal includes data sources and collection methodology.	
E. Intervention(s) – not required for projects to establish baseline; and	New Requirement	Full	Each PIP proposal includes an outline of interventions. Most proposals include multifaceted, active interventions. The Antibiotic PIP includes robust provider interventions but could include more	



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			active member interventions as noted in PIP review comments.	
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.	New Requirement	Substantial	Each PIP report includes results and interpretation. For some PIPs, the lack of improvement was attributed to an influx of new members only and there did not appear to be an analysis of interventions (CSHCN Dental, ED Utilization). Recommendation for PHP The plan should ensure that interventions are re-evaluated and a plan of action developed for PIPs that do not demonstrate improvement.	Passport Response: Passport Health Plan has acted upon IPRO's recommendation and has initiated this activity with the dental care for children with special health care needs.
The final report shall also answer the following questions and provide information on:	New Requirement			
A. Was Member confidentiality protected;	New Requirement	Full	Final PIP reports include a member confidentiality statement.	
B. Did Members participate in the performance improvement project?	New Requirement	Full	This is addressed in the final reports.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	New Requirement	Full	This is addressed in the final reports.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;	New Requirement	Substantial	As per the PIP final report, results and conclusions were to be presented to	Passport Response: Passport Health Plan has acted upon IPRO's recommendation



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			QMMC and QMAC. Recommendation: The plan should make results and conclusions of PIPs available to members, providers and any other interested bodies; the plan should clarify how this will be done in policies and procedures.	by revising policy QM 19.00 to address the results and conclusions of PIPs available to members, providers and any other interested bodies. The annual summary and/or final report will be presented to QMMC and QMAC after they are approved by DMS and IPRO.  QM 19.00 Performance Improvement
E. Is there an executive summary;	New Requirement	Full	The final report includes an abstract.	
F. Do illustrations – graphs, figures, tables – convey information clearly.	New Requirement	Full	Information is clearly presented in final PIP reports.	
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	New Requirement	Full	Submitted PIPs utilize HEDIS measures and in some cases modified HEDIS measures and goals are identified.	
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:	New Requirement	Full	Final reports include evaluation for sustained improvement; calculation of HEDIS measures utilized in the PIPs is ongoing.	



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A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full-PHP initiates a new performance improvement project each year. Proposals were submitted on September 1 st .	Full	Addressed - Two PIP proposals were submitted on 8/30/2013 (You Can Control your Asthma! Development and Implementation of an Asthma Action Plan (Asthma PIP) and Psychotropic Drug Intervention Program (Psychotropic Drug PIP).	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	Full-The four PIPs have established Baselines that were within the timeframes required.	Full	The Antibiotic PIP interim (baseline) report was submitted 8/30/13, within one year of proposal.	
C. 1 st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	Full-The PIPs have remeasurement periods one year after baseline was established.	Full	Interim report for the ED Utilization PIP was submitted 8/30/13, within two years of baseline year.	
D. 2 nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.	Full-The PIPs have 2 nd remeasurement periods that occurred or are planned for, that are one year after the first remeasurement period.	Full	The final PIP report for the Dental PIP was submitted 8/30/13, within one year of first remeasurement.	
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Full-The Plan's Quality and Member Access Advisory Committee (QMAC) meets at least four times a year and is comprised of	Full	PHP's Quality and Member Access Advisory Committee (QMAC) meets every two months and at least four times a year. The QMAC includes members and parents	



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	<p>member representatives.</p> <p>The QMAC includes representatives of children with special needs/foster care , aged populations, children and families, disabled/blind populations, public health representatives, the Commission for Children, homeless advocates and an education advocate.</p>		<p>of members, consumer advocates, and educators and considers geography, gender, age, Aid Category, race and ethnicity when selecting members. Members with disabilities and the aged as well as members representing children with special needs are also represented.</p>	
<p>Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Responsibilities of the Committee shall include:</p>	<p>Full-Membership is comprised of members, consumer advocates, educators, and public health officials who represent the public health interest and diversity of the membership, as appointed by Partnership Council.</p> <p>Appointments are made with consideration to geographic, age, gender, and aid category, as well as racial and ethnic diversity.</p>	Full	<p>Geography, gender, age, Aid Category, race and ethnicity are all factors that are considered when selecting representatives for the committee. The plan has been successful in engaging members to participate in committees.</p>	
A. Providing review and comment on quality and access	Full-The QMAC reviewed	Full	Minutes of the February 2013 QMAC	



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State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
standards;	and approved network development and practitioner access and availability reports as well as access goals as noted in committee minutes. The committee minutes also reflect review of HEDIS results, member satisfaction results and case management performance results, as well as Member Services metrics.		meetings indicate a discussion about PHP's provider access and availability reports. Other topics of discussion reflected in QMAC minutes include Care Management, Appeals, Member Satisfaction, PIPs, QI Program Evaluation and EQRO.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Full-Review of Member Services performance reports as well as grievance and appeals trends are documented in QMAC committee minutes.	Full	Minutes of the 2013 QMAC meetings indicate a discussion about member appeals and grievances.	
C. Review and provide comment on Member Handbooks;	Full-Minutes for 12/10/12 QMAC meeting demonstrate review of Member Handbook.	Full	QMAC policy indicates that the QMAC reviews Member Handbooks. Onsite staff provided QMAC minutes from that reflected mailing of the Member Handbook to committee members in November 2013, with email vote to approve the document.	
D. Reviewing Member education materials prepared by	Full-The 8/8/12 minutes of	Minimal	Other than QMAC policy that indicates the	Passport Response:



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the Contractor;	the QMAC meeting indicated that an evaluation was undertaken regarding the readability of the online provider and pharmacy directories.		committee reviews Member Handbooks, there was no evidence that member educational materials were reviewed in the minutes provided. Recommendation for PHP The plan should ensure that member education materials are reviewed by QMAC.	Passport Health Plan has acted upon IPRO's recommendation by having member materials taken to QMAC for feedback as part of the development process when initiating new member material.  CC 27 01 Development and Appi <u>Comment:</u>
E. Recommending community outreach activities; and	Full-The 9/19/12 minutes of the QMAC meeting reported on a special event at the Louisville Zoo and a Health Hoops program for members with asthma.	Full	The October 14, 2013 minutes include discussion of two large community engagement events: Healthy Hoops Kentucky and The Fall Safari for Grandparents raising Grandchildren.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full-The QMAC minutes include a review of clinical practice guidelines, the QI Program Description and Evaluation, QI Work Plans, Member Services performance reports,	Full	QMAC minutes include documentation that the committee reviewed member grievances and appeals, access and availability studies, case management activities, and contract management reports.	

Comment [SP2]: To clarify who's comment is this?



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	member grievance and appeals trend reports, member satisfaction, and HEDIS and CAHPS reports, as well as PIPs.			
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full-The QMAC minutes include members that attended and members who were absent from the meeting.	Full	QMAC minutes include members that attended and members who were excused from the meeting.	
20.8 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full-The plan conducted an annual member CAHPS survey and provider satisfaction survey during the review period and reports were provided; results were presented to the QMMC.	Full	The plan conducted its annual member CAHPS survey and provider satisfaction survey. A CAHPS report and PowerPoint presentation were submitted.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full-The CAHPS survey tool was provided to DMS.	Full	The 2013 CAHPS report prepared by Morpace, an NCQA-certified CAHPS vendor was submitted.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target	Full-PHP developed a survey that is in progress to assess the satisfaction of their	Full	The report reveals that one supplemental question was added to CAHPS: Q26a. How important is it that Passport Health Plan	



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subpopulations perspective and experience with access, treatment and services.	DCBS population. <u>Recommendation for PHP</u> PHP should consider adding supplemental questions to the annual CAHPs survey that assess satisfaction/access to services targeted to subpopulations of their membership.		reminds you that it is time for your child to see his or her doctor for care? P/P BH 17.0 outlines procedures for the DCBS population survey, and examples of the survey were provided by the plan. The plan has also developed a Case Management satisfaction survey as outlined in P/P CC 25.01.	
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's current provider satisfaction survey tool.	Full-The 2011 Practitioner Satisfaction Survey Tool was presented to the Partnership Council on 9/20/11. The plan submitted the provider satisfaction survey tool to DMS.	Full	PHP submitted a PowerPoint presentation presenting the results for its 2012 Practitioner Satisfaction Survey. The 2013 Practitioner Survey was conducted in the fall of 2013, with results to be analyzed in first quarter 2014. The plan provided attestation that the provider survey was submitted to DMS.	
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,	Full-The 2012 Adult and Child CAHPs survey reports were provided to DMS on	Full	The plan provided attestation of submission of survey reports to the Department.	



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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.	7/30/12. The Partnership Council approved the provider survey on 9/20/11.			
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full-PHP provided screenshots of the website that reference member surveys.	Full	The plan provided attestation of submission of survey reports to the Department. Results are presented to QMMC and QMAC, and there is reference to member survey on plan website.	
37.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Full-The plan provides quarterly reports that include the QAPI Work Plan and other required quality activity reports. An email sent to DMS on 1/30/12 was presented as an example.	Full	The plan provided attestation of submission of quarterly reports.	
Reference the following documents for further information: Appendix K Appendix N Appendix O				



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	93	4	2	0
Total Points	279	8	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.92		

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’ 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

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 <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section	Health Plan's and DMS' Responses and Plan of Action
24. General Requirements for Grievances and Appeals				
The Contractor shall have a grievance system in place for Members that includes a grievance process related to "dissatisfaction" and an appeals process related to a Contractor "action," including the opportunity to request a State fair hearing pursuant to KRS Chapter 13B.		Full	The plan's P/P MS 16.0 Grievance Intake Process policy details the steps the plan takes to facilitate members' grievance reporting. CP5.20 Member Appeals policy purpose is to ensure a member's right of an appeal request when he or she is dissatisfied with a resolution to a grievance. As per P/P CP5.20, all members have the right to appeal any action by a plan. Both policies state that members may contact Kentucky's Medicaid Ombudsman at any time for assistance, or request a State Fair Hearing through the Department for Medicaid Services.	
The Contractor shall implement written policies and procedures describing how the Member may submit a request for a grievance or an appeal with the Contractor or submit a request for a state fair hearing with the State. The policy shall include a description of how the Contractor resolves the grievance or appeal.		Full	The above noted P/P MS 16.0 and CP 5.20 describe how members may submit a request for grievance or appeal and how the plan resolves the grievance or appeal. The Administrative/Benefits Appeals Committee meets every three weeks to review administrative or benefits appeals and renders appeal decisions. Persons on the committee will not have been involved in the action being appealed. A decision could be to uphold, overturn, or modify an action. The appeals research specialist	



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			<p>completes the decision letter and forwards it to the medical management clinical program manager for review and audit.</p> <p>Enclosed in the decision letter is the information regarding how to file a Fair Hearing request and how to contact the Office of the Ombudsman. It is sent to the member with copies to the peer review organizations, provider and facility as appropriate. The process for the plan's participation in members' initiated request for State fair hearing are described in P/P CP 27.0 State Hearings.</p>	
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.		Full	Addressed in CP 5.20 Appeals Policy. The processes for filing appeals and grievances on members' behalf are communicated to providers in the Provider Manual (Sections 6.10-6.11) as well as in the Provider Kit.	
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.		Full	The availability of assistance in completing forms is addressed in MS 11.0 Member Services Departments Function and MS 24.0. The availability of assistance with questions is communicated to members in the Member Handbook, in member	



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			<p>newsletter My Life/My Health, and in template letters for notices of action and the various forms of appeals. Members may also call the plan's Member Services department for help filing an appeal using toll-free numbers available in Handbook and on Member Newsletter. The Provider Kit documents the availability of trained interpreters.</p> <p>The availability of Interpreters is included in the Member Handbook. The availability of TTY/TTD numbers is included in grievance and appeal policies and is in notice of action letters and appeal acknowledgement letters as in P/P UM 11.0 and UM 27.01, Staff Access for Members and Providers to discuss Utilization and Management issues and processes.</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>		Full	<p>The plan has an Appeals Coordinator dedicated to processing Medicaid Member appeals to resolution as documented in the Appeals Policy CP 5.20. The availability of the coordinator to assist members is documented and communicated to members in the Member Handbook, the Member Newsletter, and the various DMS approved appeals template letters. The</p>	



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			Appeals Coordinator and responsible staff persons for appeals are named on the QI 2013 Work Plan.	
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:		Full	This requirement is addressed in CP 5.20 Member Appeal Policy. This information is communicated to members in the Member Handbook, and appears in template appeal letters.	
A. An appeal of a Contractor denial that is based on lack of medical necessity;		Full	This requirement is addressed in Policy CP 5.20. <u>Appeal File Review</u> All reviewed files of appeals included evidence that a physician was responsible for the decision.	
B. A Contractor denial that is upheld in an expedited resolution; and		Full	This requirement is addressed in Policy CP 5.20. <u>Appeal File Review</u> There were no applicable expedited appeal files in the file review sample.	
C. A grievance or appeal that involves clinical issues.		Substantial	This requirement is addressed in Policy CP 5.20 and MS 16.0. <u>Appeal File Review</u> All appeals files involving clinical issues included evidence of decisions by	



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			<p>physicians.</p> <p><u>Grievance File Review</u> 19/20 member grievance files were clearly resolved by clinical staff. 1/20 member grievance files, which involved a complaint regarding a provider that was referred to a subcontractor, was not clearly reviewed by clinical staff, although assistance was given for identifying a new provider.</p> <p><u>Recommendation for PHP</u> The plan should ensure that member grievances relating to clinical care are reviewed by health care professionals.</p>	<p>Passport Response: Passport agrees with the recommendation.</p>
The Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook, Member Newsletter, and template appeals letters.	
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.		Full	This requirement is addressed in P/P CP 5.20 and in P/P CP 5.14 Provider Administrative Appeals and P/P CP 5.12 Provider Post Service Medical Appeals. This information is included in the	



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			Member Handbook and template action and appeal letters.	
24.1 Grievance Process				
A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.				
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member.		Full	This requirement is addressed in P/P MS 16.0 Grievance Intake Process and information is communicated to members in the Member Handbook and Members Newsletter.	
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.		Full	This requirement is addressed in P/P MS 16.0 Grievance Intake Process. This information is communicated to members in the Member Handbook and Members Newsletter. <u>Grievance File Review</u> All reviewed grievance files included documentation that grievances were acknowledged within five working days.	
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days		Full	Addressed in CP 5.20. Communicated to members in the Member Handbook and	



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of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant.			DMS approved template letter. <u>Grievance File Review</u> A total of 19/20 reviewed files were resolved within thirty days, with 1/20 files requiring extension due to difficulty obtaining medical records from the provider. The plan was aggressive in pursuing these records in order to complete a comprehensive review of the grievance, and ultimately had to send a provider representative to retrieve records from the provider site. These extenuating circumstances resulted in delay of resolution until five days past the extension period.	
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.		Full	This requirement is addressed in P/P MS 16.0 Grievance Intake Process. This information is communicated to members in the Member Handbook and appears in template letters provided by the plan. <u>Grievance File Review</u> One file included a request for extension, and extension letter was within timeframes and included required information.	
Upon resolution of the grievance, the Contractor shall mail a		Full	This requirement is addressed in Policy	



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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:			MS 16.0 Grievance Intake Process. <u>Grievance File Review</u> All reviewed member grievance files included resolution letters.	
A. All information considered in investigating the grievance;		Full	This requirement is addressed in MS 16.0. <u>Grievance File Review</u> All reviewed member grievance files included a description of information considered in the review.	
B. Findings and conclusions based on the investigation; and		Full	This requirement is addressed in P/P MS 16.0. <u>Grievance File Review</u> All reviewed files included findings and conclusion based on the investigation.	
C. The disposition of the grievance.		Full	This requirement is addressed in P/P MS 16.0. <u>Grievance File Review</u> All reviewed files included the disposition of the grievance.	
24.2 Appeal Process				



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An appeal is a request for review by the Contractor of a Contractor action.				
A. An action for purpose of an appeal is:				
(1) the denial or limited authorization of a requested services, including the type or level of service;		Full	Addressed in CP 5.20. This information is communicated to members in the Member Handbook and Member Newsletter.	
(2) the reduction, suspension, or termination of a previously authorized service;		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and Member Newsletter.	
(3) the denial, in whole or in part, of payment for a service;		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and Member Newsletter.	
(4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and Member Newsletter.	
(5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and Member Newsletter.	
(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		Substantial	This requirement is generally addressed in CP 5.20 which covers the denial of a request to obtain services outside the	



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network.			<p>network for specific reasons. The policy does not explicitly refer to rural residents. Information regarding denials is communicated to members in the Member Handbook and member Newsletter 3rd ed. 2013, although not explicit information regarding denials relevant to rural members or out-of-network denials. Onsite, staff indicated that sole contractor status in a rural area was not a current issue.</p> <p><u>Recommendation for PHP</u> The plan should include information regarding out of network requests in rural areas as applicable in policies/procedures and member information.</p>	<p><u>Passport Response:</u> Passport acknowledges the recommendation and has updated CP 5.20, under definitions: Action or Adverse Action (in yellow).</p> <p style="text-align: center;"> CP 5 20 Member Appeals with 2013 DN</p> <p><u>Comment:</u> Passport Health Plan should ensure that this Information is communicated to Providers and Members.</p>
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:		Full	<p>Notice of action is addressed in P/P CP 5.20 Member Appeals. P/P UM 11.01 Denial of Service includes a template Notice of Action letter.</p> <p><u>UM File Review</u> All reviewed files included appropriate notice of action letter.</p>	
(1) the action the Contractor has taken or intends to take;		Full	<p>This requirement is addressed in P/P CP 5.20 Member Appeals and UM 11.01.</p>	

Comment [SP1]: Identify whose comment this is.



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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
			<u>UM File Review</u> All reviewed files included notice of action letters specifying the action taken or that the plan intends to take.	
(2) the reasons for the action;		Full	This requirement is addressed in CP 5.20 and UM 11.01. <u>UM File Review</u> All reviewed files included notice of action letters that included the reason 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;		Full	This requirement is addressed in CP 5.20 and P/P UM 11.01. <u>UM File Review</u> All reviewed files included letters outlining the member's or provider's right to appeal.	
(4) the Member's right to request a state fair hearing and what the process would be;		Full	This requirement is addressed in CP 5.20 and UM 11.01. This information is communicated to members in template notice of action letter. <u>UM File Review</u> All reviewed files included notice of action letters that included right to request a state fair hearing.	
(5) the procedures for exercising the rights specified;		Full	This requirement is addressed in CP 5.20	



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			and UM 11.01, and communicated to members in notice of action template letter. <u>UM File Review</u> All reviewed files included notice of action letters with the required information.	
(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and		Full	This requirement is addressed in CP 5.20, UM 11.01 and is communicated to members in the notice of action template letter. <u>UM File Review</u> All reviewed files included letters with this information.	
(7) the Member's right to have benefits continue pending resolution of an appeal or state fair hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.		Full	This requirement is addressed in CP 5.20 and UM 11.01. <u>UM File Review</u> All reviewed files included notice of action letters that included this information.	



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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	This requirement is addressed in CP 5.20 and UM 11.01. P/P UM 11.01 indicates that notices will be mailed within ten days of action. Immediate notification for denials of claims that may result in member financial liability is not addressed in policies/procedures. <u>Recommendation for PHP</u> The plan should address immediate notification for denials of claims that may result in member financial liability in policies and procedures.	<u>Passport Response:</u> Passport agrees with the recommendation and has updated CP 5.20, #13 and UM 11.01, #6  CP 5 20 Member Appeals with 2013 DN  UM 11 01 Denial of Services (2).docx <u>Comment:</u> Passport Health Plan should ensure that this Information is communicated to Providers and Members.
C. A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the appeal.		Full	This requirement is addressed in CP 5.20. The information is communicated to members in the Member Handbook and Member Newsletter.	
D. The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor		Full	This requirement is addressed in CP 5.20. Communicated to members in the	

Comment [SP2]: Identify whose comment this is.



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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.			Member Handbook, Member Newsletter, and DMS approved template letter. <u>Appeal File Review</u> All reviewed appeals files included resolution within 30 calendar days of receipt of the initial appeal and all were reviewed by physicians not involved in the initial appeal decision.	
E. The Contractor shall have a process in place that ensures that an oral or written inquiry from a Member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the Member within ten (10) calendar days. The Contractor shall use its best efforts to assist Members as needed with the written appeal and may continue to process the appeal.		Full	This requirement is addressed in CP 5.20 and MS 16.0 Grievance Intake Process. This information is communicated to members in the Member Handbook, Member Newsletter, and the template letter. The acknowledgement letter includes information regarding help with questions regarding filing appeals. Information regarding available assistance also appears in P/P CP 5.20.	
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.		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and in the acknowledgement template letter. <u>Appeal File Review</u> 10/10 member appeals files included written acknowledgement within five	



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			working days of receipt of appeal.	
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.		Full	This requirement is addressed in CP 5.20. Communicated to members in the Member Handbook and in the acknowledgement template letter. <u>Appeal File Review</u> All reviewed files were compliant with requirement.	
H. The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.		Full	This requirement is addressed in CP 5.20. Communicated to members in the Member Handbook and in the acknowledgement template letter. <u>Appeal File Review</u> All reviewed files were compliant with requirement.	
I. The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.		Full	This requirement is addressed in CP 5.20. Communicated to members in the Member Handbook and in the acknowledgement template letter. <u>Appeal File Review</u> All reviewed files were compliant with requirement.	
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		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook	



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appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information:			and template letters. <u>Appeal File Review</u> All reviewed appeal files included timely appeal resolution letters.	
(1) the results and reasoning behind the appeal resolution; and		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and template letters. <u>Appeal File Review</u> All reviewed appeal files included letters with results and reasoning behind resolution.	
(2) the date it was completed.		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and template letters. <u>Appeal File Review</u> All reviewed appeal files included letters with date of completion of resolution.	
K. The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information:		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and template letters.	
(1) the right to request a state fair hearing and how to do so;		Full	This requirement is addressed in CP 5.20. This information is communicated	



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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
			to members in the Member Handbook and template letters. <u>Appeal File Review</u> All reviewed files not resolved wholly in the member's favor included information regarding state fair hearing.	
(2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and		Substantial	This requirement is addressed in P/P CP 5.20. The policy states that the notice shall conform to the requirements of KRS 13B.050(3)(d) and (e). This policy states that benefits will continue if the member requests a state fair hearing within 30 days of an action. This information is also included in notice of action as per P/P UM 11.01. The template letter for members whose appeal was upheld indicates that members will not lose benefits if they request a fair hearing. Other member documents refer to right to request receipt of benefits while appeal is pending but not explicitly while state fair hearing is pending. The plan indicated onsite that this is applicable, since the state fair hearing is a form of appeal. <u>Recommendation for PHP</u> The plan should clarify that member rights to request continuing benefits	Passport Response: Passport agrees with the recommendation and has updated CP 5.20, #4 and UM 11.01, #7m  CP 5 20 Member Appeals with 2013 DN  UM 11 01 Denial of Services (2).docx <u>Comment:</u> Passport Health Plan should ensure that this Information is communicated to Providers and Members.

Comment [SP3]: Identify whose comment this is.



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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
			pending appeal applies to all appeals, including state fair hearing.	
(3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action.		Substantial	<p>This requirement is addressed in CP 5.20. This information is communicated to members for appeals in general in the Member Handbook and final appeal decision upholding action letter, but not specifically for a state hearing, which is a type of appeal.</p> <p><u>Appeal File Review</u> All reviewed files not resolved wholly in the member's favor included information regarding continuation of benefits.</p> <p>Recommendation for PHP The plan should clarify that member rights to request continuing benefits pending appeal applies to all appeals, including state fair hearing.</p>	<p>Passport Response: Passport agrees with the recommendation and has updated CP 5.20, #4 and UM 11.01, #7m</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  CP 5 20 Member Appeals with 2013 DN </div> <div style="text-align: center;">  UM 11 01 Denial of Services (2).docx </div> </div> <p><u>Comment:</u> Note that this particular requirement relates to the Member being liable for the cost of benefits provided during appeal/SFH if the SFH uphold's the MCO decision.</p> <p>P/P CP 5.20 Member Appeals, page 3, item #4 addresses this by stating: "If final decision is adverse to member, the member may be required to pay for services <u>provided</u> while the appeal was pending."</p> <p>Passport Health Plan should revise the wording to include the word 'provided' as</p>

Comment [SP4]: Identify whose comment this is.

Comment [SP5]: Is this word actually underlined since is a quote?



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				noted above. Passport Health Plan should update P/P UM 11.01 Denial of Services to include this statement. Additionally, Passport Health Plan should ensure that this information is communicated to Providers and Members.
L. The Contractor shall continue the Member's benefits if all of the following are met:		Full	Continuation of benefits is addressed in CP 5.20.	
(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;		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and template letter.	
(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and template letter.	
(3) the services were ordered by an authorized service provider;		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and template letter.	
(4) the time period covered by the original authorization has not expired; and		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and template letter.	
(5) the Member requests extension of the benefits.		Full	This requirement is addressed in CP 5.20 and communicated to members in the Member Handbook and template letter.	



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M. The Contractor shall provide benefits until one of the following occurs:				
(1) The Member withdraws the appeal;		Full	This requirement is addressed in CP 5.20.	
(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;		Full	This requirement is addressed in CP 5.20.	
(3) The Cabinet issues a state fair hearing decision adverse to the Member;		Full	This requirement is addressed in CP 5.20.	
(4) The time period or service limits of a previously authorized service has expired.		Full	This requirement is addressed in CP 5.20.	
N. If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).		Full	This requirement is addressed in CP 5.20.	
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		Full	This requirement is addressed in CP 5.20.	



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pay for these services.				
24.3 Expedited Resolution of Appeals				
An expedited resolution of an appeal is an expedited review by the Contractor of a Contractor action.				
A. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook. <u>Appeal File Review</u> There were no expedited appeals in the appeals file review sample.	
(1) a request from the Member;		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook.	
(2) a provider's support of the Member's request;		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook.	
(3) a provider's request on behalf of the Member; or		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook.	
(4) the Contractor's independent determination.		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook.	
The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.		Full	This requirement is addressed in CP 5.20, and communicated to members in	



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			the Member Handbook.	
B. The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice.		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook.	
C. The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook and also in letter template.	
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.		Full	This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook.	
F. The Contractor shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the Member or service provider on behalf of the Member.		Full	This requirement is addressed in CP 5.20.	
G. The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.		Substantial	This requirement is addressed in CP 5.20. The Member Handbook and Notice of Action indicate that resolution for expedited appeals is within 72 hours. Language does not specifically state the limited time available for the member to	Passport Response: Passport agrees with the recommendation and has updated the Notice of Action, Attachment A to UM 11.01. The Member Handbook will be updated at the next review.



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			present evidence and allegations. Recommendation for PHP The Member Handbook and Notice of Action should explicitly inform the member of the limited time available for the member to present evidence and allegations for expedited appeals.	 UM 11 01 Denial of Services (2).docx <u>Comment:</u> Passport Health Plan should provide the revised Handbook to DMS for review and approval once the revision is completed.
H. If the Contractor denies a request for an expedited resolution of an appeal, it shall:				
(1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and		Full	This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook.	
(2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days.		Full	This requirement is addressed in CP 5.20.	
I. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.		Full	This requirement is addressed in CP 5.20.	
24.4 State Hearings for Members				
A Member may request a State Fair Hearing if he or she is		Full	This requirement is addressed in CP	

Comment [SP6]: Identify whose comment this is.



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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.			5.20. This information is communicated to members in the Member Handbook.	
All documents supporting the Contractor's Action must be received by the Department no later than five (5) days from the date the Contractor receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. The Department will provide the Member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.		Full	This requirement is addressed in CP 27.0 State Hearings Policy. The availability of these records is communicated to members in the template letter: Medical Director Letter – Final Appeal Decision Upholding Action.	
Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.		Full	State fair hearings and complying with requirements are addressed in P/P CP 27.0 State Hearings Policy.	
27.8 Provider Grievances and Appeals				
The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or 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		Full	Provider Post Service Medical Appeals Policy CP 5.12 and the Provider Manual Section 6.11 detail policies and procedures for filing provider grievances and appeals. These policies are communicated to providers in the Provider Manual as described above as well as in the Provider Kit, which provides a toll-free number for Provider	<p>Passport Response: Passport agrees with the recommendation</p> <p>Comment: Implementation of documenting that the Provider was notified of the resolution of the grievance will be checked in the file review process during the next annual compliance review.</p>

Comment [SP7]: Identify whose comment this is.



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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.			Appeals assistance. <u>Provider Appeal File Review</u> All provider appeals files revealed timely resolution. <u>Provider Grievance File Review</u> All provider grievances were resolved within 30 days. There were some files for which documentation was not clear that providers were informed of resolutions in their favor. Onsite staff indicated that since resolutions were on the same day, the provider was notified at the time of the grievance. For grievances which were determined to be error or lack of familiarity with the policies of the provider, all had documentation that the provider was educated regarding policy and procedure. <u>Recommendation for PHP</u> The plan should ensure that documentation reflects notification of providers of resolution of grievance.	
27. 9 Other Related Processes				
The Contractor shall provide information specified in 42 CFR		Full	This requirement is addressed in the	



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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
438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.			Provider Manual and Provider Kit.	
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.		Minimal	P/P UM 30.0 Confidentiality and Privacy addresses this requirement, and described locked files for paper records and scanning and maintaining files electronically. This policy indicates that denials will be retained for 7 years following final decision or closure. The policy does not address grievance files specifically. Recommendation for PHP The plan should ensure that policies and procedures reflect the requirement that files be maintained for 10 years not 7 years, and address grievance files.	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by revising Policy UM 30.0, Confidentiality and Privacy Guidelines – Utilization Management Department, to include 10 years, not 7 years. See page 4.  UM 30 0 Confidentiality and Pri <u>Comment:</u> The P/P addresses this requirement relative to appeal files. Passport Health Plan also needs to take action to ensure that this requirement is addressed in P/P relative to grievances.
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.		Full	This requirement is addressed in Grievance Intake Process Policy (MS 16.0) and P/P PC 18.0 Claim Appeals Process, as well as Member Appeals P/P 5.20.	

Comment [SP8]: Identify whose comment this is.



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Grievance System (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Documentation regarding the grievance shall be made available to the Member, if requested.		Minimal	<p>P/P MS 16.0 indicates that information considered in resolution of the grievance is provided in resolution letters. Grievance and appeal policies and procedures do not otherwise address making documentation regarding the grievance available to members if requested. Onsite staff indicated that there are formal procedures for members requesting records in general.</p> <p><u>Recommendation for PHP</u> The plan should reference procedures for members requesting documentation related to grievances including routing such requests to other departments, in grievance and appeals policies and procedures.</p>	<p>Passport Response: Passport Health Plan respectfully disagrees with this finding. Procedures for members requesting Protected Health Information are provided in Policy PHP23, Member Right of Access to Protected Health Information, starting on page 6, which was provided to IPRO onsite while at Passport.</p> <p style="text-align: center;"> PHP 23 - Member Right of Access to Pro</p> <p><u>Final Review Determination:</u> No change in compliance level.</p> <p>The P/P provided is general and does not specifically address the Member right to access Grievance documentation. Passport Health Plan should include this right in its P/Ps for Grievances and may reference that grievance Documentation will be shared in accordance With P/P PHP 23 Member Right of Access to Protected Health Information.</p> <p>Additionally, Passport Health Plan should ensure that this information is communicated to Providers and Members.</p>

Comment [SP9]: In caps.

Comment [SP10]: In caps.

Comment [SP11]: In caps.



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Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	74	6	2	0
Total Points	222	6 12	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.89		

Comment [WU12]: 2.88

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

Reviewer Decision:

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

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

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



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Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

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

Process for quality oversight of grievance processing

Evidence of quality oversight and follow-up for grievance processing

Reports

Quarterly reports of grievances and appeals

File Review

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

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

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



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Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
34.1 Health Risk Assessment				
The Contractor shall have programs and processes in place to address the preventive and chronic healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.		Full	PHP's programs and processes to assess, monitor and evaluate needs of its population are outlined in P/P Health Risk Assessment (HRA) Management Policy No. CC 2.00.	
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.		Full	<p>P/P CC 2.00 Health Risk Assessment (HRA) Management (section 1 and 7) describes the process and procedure for health risk screening for the needs of new and/or re-enrolled members (members not enrolled in the previous 12 months) within 90 days of enrollment and 30 days for members believed to be pregnant, who if pregnant will be referred for appropriate prenatal care. The Mommy Steps Case Manager completes the HRA for newborn enrollees or mothers during postpartum hospital onsite visits.</p> <p>P/P CC 2.00 (section 7) Health Risk Assessment (HRA) Management outlines the outreach procedure for health risk assessment that is conducted by the plan's contracted vendor, which includes at least three outreach attempts by telephonic, mailed outreach and/or in person. The</p>	



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Health Risk Assessment
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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>policy does not state specific time frames for completing each outreach attempt but overall the outreach process must be completed within 90 days of enrollment. Onsite staff indicated that initial outbound calls are conducted within 15 days, then another outreach is conducted 15 days post the initial attempt if there has been no response, with a goal of successful contact within 60 days. The assessment consists of a screening tool to assist in stratifying members' risks. The information collected identifies the health education needs of members and allows follow up and intervention by Care Coordination staff. The vendor process for outreach is described in the P/P CC 2.00 (section 7) that the plan provided. HRA data are included as a data source for member identification for members requiring Immediate Care, Health Management, Disease Management or Care Management.</p> <p><u>HRA File Review</u> 4/20 reviewed case files included documentation that the HRA was completed within appropriate timeframes. An HRA was not completed in 16 files despite multiple attempts to engage the member. All (20/20) reviewed files included timely outreach (within 90 days for non pregnant members and 30 days for pregnant members). In some cases, members were retroactively</p>	



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Health Risk Assessment (See Final Page for Suggested Evidence)				
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			enrolled, and the outreach was within timeframes from the receipt of the plan's eligibility file rather than the identified enrollment date. These files were identified as retroactive enrollments.	
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.		Substantial	<p>Health Risk Assessment (HRA) Management Policy No. CC 2.00 includes reasonable efforts to contact members (telephonic, by mail and/or in person) as per contract language. While the policy indicates that telephonic outreach can be live or automated, there is no specificity regarding when members are identified for in person outreach. Onsite staff indicated that members without phones are targeted for in person outreach. Two of the four successful HRAs in the reviewed file included in-person outreach.</p> <p>Specific outreach procedures were described by onsite staff, who indicated that the initial outreach attempt is a new member mailing, conducted when the plan becomes aware of the enrollee. The plan conducts outreach calls 15 days later and then a third attempt (reminder postcard) after the next 15 days if there is no response, in order to ensure completion within 90 days.</p> <p><u>HRA File Review</u> All reviewed files included evidence of outreach within specified timeframes above.</p>	Passport Response: Passport acknowledges the recommendations.



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			<p>Onsite staff indicated that initial outreach is the new enrollee mailing, which includes an HRA, although this attempt is not currently included in the tracking database. Onsite staff provided a summary of initial mailings for the file sample; this information was maintained separately.</p> <p>A total of 18/20 files contained evidence of two additional outreach attempts. Two files had documentation of only initial mailing and one additional mailing; onsite staff indicated that one of these members had no phone. The other member had a notation of a chronic condition in the file.</p> <p>Recommendation for PHP The plan should include initial contact attempt in tracking database, and clarify policy/procedures regarding when in-person attempts are initiated, e.g. for members with no phone.</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.		Substantial	<p>This requirement is addressed in CC 2.00, which includes the Adult Health Risk Assessment Form and the Pediatric Health Risk Assessment Form.</p> <p><u>HRA File Review</u> All three of the completed HRAs reviewed included all appropriate information. The plan was unable to locate the electronic HRA for the fourth member with a completed</p>	Passport Response: Passport agrees with the recommendation.



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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>HRA, although documentation indicates that the member was referred to Mommy Steps for further assessment and management.</p> <p><u>Recommendation for PHP</u> Completed HRAs should be available for review.</p>	
The Contractor shall use appropriate healthcare professionals in the assessment process.		Substantial	<p>CC 2.00 does not specify the role of health professionals in the assessment process, although there is reference to follow-up and intervention by care coordination staff (health management, disease management, and case management) for members needing immediate case or disease management assistance. How members are identified to have such immediate need is not explicit in P/P CC 2.00. Onsite staff indicated that the care coordination staff identified in Policy 2.00 is health professionals.</p> <p><u>Recommendation for PHP</u> The plan should clarify the role of healthcare professionals in the assessment process in policies/procedures.</p>	<p><u>Passport Response:</u> Passport acknowledges the recommendations.</p>
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventative services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions.		Substantial	<p>This requirement is addressed in CC 2.00, section 7.B. Representatives assist members by completing the HRA form telephonically. During the outreach call the Representatives offer members assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive</p>	<p><u>Passport Response:</u> Passport agrees with the recommendation.</p>



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Health Risk Assessment (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			<p>services, including an assessment or screening of the member's potential risk, if any, for specific diseases or conditions.</p> <p><u>HRA File Review</u> All (3/3) files with completed HRAs included assessment of need for assistance with arranging an initial visit with PCP; the file of one member indicated that assistance was needed in scheduling an appointment but there is no evidence in the file that this assistance was provided.</p> <p><u>Recommendation for PHP</u> The plan should ensure that all members indicating a need for assistance with PCP visits are provided assistance.</p>	
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.		Full	The plan provided evidence of submission of MCO #79 quarterly reports dated 4/22/13, 7/2013, 10/21/13, 01/14/14, which include the required information.	



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Health Risk Assessment

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.43		

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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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
27.2 Provider Credentialing and Recredentialing				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,		Full	P/P CR 1.01 Practitioner Credentialing addresses the procedure followed to credential practitioners. P/P CR 4.01 Practitioner Re-Credentialing addresses the procedure followed to recredential practitioners minimally every three years.	
defining the scope of providers covered,		Full	P/P CR 1.01 Practitioner Credentialing and CR 4.01 Practitioner Re-Credentialing address this requirement.	
the criteria and the primary source verification of information used to meet the criteria,		Full	P/P CR 18.2 OPTUM PSV and PHP Provider Enrollment address primary source verification activities performed by OPTUM, a NCOA Credentialing Verifications Organization. OPTUM performs all non-delegated primary source verifications for initial and recredentialing for practitioners and facilities not performed by PHP. P/P CR 1.01 Practitioner Credentialing and CR 4.01 Practitioner Re-Credentialing address primary source verification.	
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.		Full	P/P CR 1.01 Practitioner Credentialing and CR 4.01 Practitioner Re-Credentialing address the decision making process. P/P CR 18.2 OPTUM PSV and PHP Provider	



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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
			Enrollment address delegated credentialing and recredentialing. P/P CR 2.01 Responsibilities of the Chief Medical Officer and the Credentialing Committee addresses this requirement.	
The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.		Full	P/P CR 3.01 Practitioner Review, Hearing and Appeal of Credentialing Matters, P/P CR 1.01 Practitioner Credentialing and CR 4.01 Practitioner Re-Credentialing address the process for receiving input from providers regarding credentialing and recredentialing.	
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.		Full	P/P CR 2.01 Responsibilities of the Chief Medical Officer and the Credentialing Committee states that the Credentialing Committee includes up to ten members with representation from various providers eligible for network provider participation. Credentialing Committee Membership document listed two voting members plus four PHP associates. The membership documents provided show that all Committee members are licensed certified practitioners. <u>Recommendation for PHP</u> The plan should add the specific provider types that serve as members of the Credentialing Committee to their policies and procedures.	<u>Passport Response:</u> Passport agrees with the recommendation.



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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.		Full	P/P CR 1.01 Practitioner Credentialing addresses which providers are required to be credentialed. January & February 2013 Credentialing Committee minutes show evidence of hospital-based providers under review by the committee.	
The contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.		Full	P/P CR 1.01 & CR 4.01 address the requirement that the Plan verify that its enrolled network Providers are properly licensed according to Commonwealth laws and regulations and have current malpractice insurance. <u>Credentialing/Recredentialing File Review</u> A review of 20 sample files showed that all contained verification of provider credentials as well as verification of malpractice insurance.	
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.		Full	Documents provided (CR 1.01 through CR 21.0) address the requirement that verification of provider credentials and insurance, and further verification and periodic review of provider performance, shall be in written policies and procedures.	



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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			These procedures and policies are communicated to the provider through the Provider Manual.	
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.		Full	P/P CR 1.01 and P/P CR 4.01 address the requirement that a file shall be maintained for each provider and that such file contain a copy of the Provider's current license. <u>Credentialing/Recredentialing File Review</u> The plan had a file for every provider in the sample (20 of 20). Each file contained proof of current licensure.	
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.		Full	P/P CR 1.01 addresses the requirement that the process for verification of credentials and insurance be in accordance with the Department's policies and procedures. <u>Credentialing/Recredentialing File Review</u> 20 of 20 files reviewed in the sample contained completed credentialing applications in accordance with the requirements in KRS 295.560(12).	
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;		Full	P/P CR 1.01 and CR 4.01 address the requirement that the plan's policies and procedures contain the initial process for credentialing as well as its recredentialing processes.	



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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			This requirement is communicated to providers in the Provider Manual. The providers are made aware of the process for initial credentialing as well as the requirement that recredentialing occurs at least every three (3) years.	
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;		Full	Addressed in P/Ps CR 1.01, CR 2.01, and CR 4.01. The Credentialing Committee formally governs the credentialing of the plan's providers.	
C. A review of the credentialing policies and procedures by the formal body;		Full	Addressed in P/P CR 2.01.	
D. A credentialing committee which makes recommendations regarding credentialing;		Full	Addressed in P/P CR 2. The plan provided documentation of the meetings held by the Credentialing Committee.	
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;		Full	P/P CR 18.0 University of Louisville Physicians Credentialing Delegate addresses this requirement. The plan provided documentation that the credentialing performed by University of Louisville was effective. This monitoring is performed by the Credentialing Committee.	
F. Written procedures for the termination or suspension of Providers; and		Full	Addressed in PC 11.0 – Provider Termination Notice to DMS. This requirement is communicated to providers through the Provider Manual.	



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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.		Full	P/P PC 11.0 Provider Termination Notice to DMS addresses this requirement.	
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:		Full	P/P CR 1.01 and CR 4.01 address this requirement.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.		Full	Addressed in P/P CR 1. <u>Credentialing/Recredentialing File Review</u> 20 of 20 files reviewed showed proof of valid, current licensure for the providers.	
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;		Full	P/P CR 1.01 and CR 4.01 address this requirement. <u>Credentialing/Recredentialing File Review</u> 20 of 20 files showed proof of DEA certificate.	
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not Board Certified.		Full	Addressed in P/P CR 1. <u>Credentialing/Recredentialing File Review</u> 20 of 20 files reviewed were compliant.	
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> Of the 20 files reviewed, Board certification was provided for all 20.	



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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (See Final Page for Suggested Evidence)				
State Contract Requirements (Federal Regulation 438.214)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;		Full	This requirement is addressed in the Practitioner Credentialing and Recredentialing Policies.	
F. Previous five (5) years work history;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> All of the files reviewed met this requirement (20 of 20).	
G. Professional liability claims history;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files provided proof of 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;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed were compliant.	
I. Current, adequate malpractice insurance, as verified through attestation;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed were compliant.	
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;		Full	Addressed in P/P CR 1.01. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed were compliant.	



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K. Documentation of curtailment or suspension of medical staff privileges;		Full	This requirement is addressed in PP CR 1.01. The credentialing process verifies sanctions restrictions and limitations that cover the most recent five year period for all states where the provider practiced. <u>Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.</u>	
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.</u>	
M. Documentation of censure by the State or County professional association; and		Full	This requirement is addressed in PP CR 1.01. <u>Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.</u>	
N. Most recent information available from the National Practitioner Data Bank.		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.</u>	
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review 20/20 files reviewed contained the required language in the credentialing application.</u>	



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B. Lack of present illegal drug use;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed contained the required language in the credentialing application.	
C. History of loss of license and felony convictions;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed contained the required language in the credentialing application.	
D. History of loss or limitation of privileges or disciplinary activity;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed contained the required language in the credentialing application.	
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and		Full	P/P CR 1.01 address this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed contained the required language in the credentialing application.	
F. Applicant attests to correctness and completeness of the application		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed contained the required language in the credentialing application and all attestations were attested to and signed by the applicants.	



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Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed were compliant.	
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and		Full	P/P CR 1.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed were compliant.	
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.		Full	P/P CR 1.01 addresses this requirement.	
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and/or as required by law.		Full	PNM Site Visit Form and P/P PR 57.0 Provider Office Site Visit submitted. PR 57.0 states that at the time of credentialing, the Provider Network Management Representative may perform an initial site visit, as deemed necessary. Generally, P/P indicates site visits as a result of member complaints. Complaint threshold requiring an onsite visit is 5 or more complaints within a 6 month period.	
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this		Full	P/P PR 57.0 and PNM Site Visit Form address this requirement.	



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contract.			As applicable, the plan conducts and documents structured reviews to evaluate the site against its standards and against those standards specified by the department.	
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.		Full	P/P PR 57.0 Provider Office Site Visit addresses the evaluation of medical record documentation and medical record keeping practices. Documentation was provided onsite that shows that the plan documents the evaluation of the medical record documentation and medical record keeping practices for conformity with plan and department standards.	
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:		Full	P/P CR 4.01 addresses the requirement that the plan have formalized recredentialing procedures. <u>Credentialing/Recredentialing File Review</u> All files reviewed within the sample that involved recredentialing showed evidence that the plan upheld this requirement. All recredentialing took place within three years of the initial credentialing.	
A. A current license to practice;		Full	P/P CR 4.01 addresses this requirement. <u>Credentialing/Recredentialing File Review</u> 20/20 files reviewed were compliant.	



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B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
C. A valid DEA, if applicable;		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recertified;		Full	P/P CR 4.01 addresses board certification for recertification. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and		Full	P/P CR 4.01 addresses this requirement Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
F. A current signed attestation statement by the applicant regarding:		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
1. The ability to perform the essential functions of the position, with or without accommodation;		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
2. The lack of current illegal drug use;		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	



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3. A history of loss, limitation of privileges or any disciplinary action; and		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
4. Current malpractice insurance.		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :		Full	P/P CR 4.01 addresses this requirement.	
A. The national practitioner data bank;		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
B. Medicare and Medicaid;		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
C. State boards of practice, as applicable; and		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.		Full	P/P CR 4.01 addresses this requirement. Credentialing/Recredentialing File Review 20/20 files reviewed were compliant.	
The Contractor will use the format provided in		Full	This requirement is addressed in CR 13.0 –	



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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.			Provider Enrollment with the Department for Medicaid Services.	
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.		Full	P/P CR 10.01 Ongoing Monitoring of Sanctions and CR 11.01 Practitioner Sanctioning and Reporting Policy address this requirement. Evidence of ongoing monitoring was evidenced in each credentialing file.	
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.		Full	P/P CR 6.01 Organizational Provider Credentialing/Re-credentialing Policy and Procedures state that PHP evaluates performance-monitoring data and re-verifies credentialing information that is subject to change. Credentialing Committee meeting minutes, agendas, and University of Louisville Physicians (ULP) Annual Survey example address this requirement.	
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		Full	P/P CR 4.01 addresses this requirement. The plan provided evidence that at least every three years they confirm that the providers are in good standing with the state and federal governing bodies, including the	



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agency or has met standards of participation required by the Contractor.			Department.	
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.		Full	P/P CR 11.01 Practitioner Sanctioning and Reporting Policy address this requirement.	
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.		Full	P/P CR 11.01 Practitioner Sanctioning and Reporting Policy address this requirement.	
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.		Full	P/P CR 11.01 Practitioner Sanctioning and Reporting Policy address this requirement.	
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Types.htm		Full	P/P CR 13.0 addresses this requirement.	
28.1 Network Providers to be Enrolled				
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		Substantial	LOB1300 Passport Annual Report provides accessibility for PCPs, Dental, Specialty providers, Non-Physician Providers, Hospitals, Urgent Care Ctrs., FQHCs, Pharmacy, Family Planning Clinics, Maternity, Vision, and BH. Requirements pertaining to FQHC are	



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<p>Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment 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>addressed in PC 84.0 Behavioral Health Provider contracting and Enrollment.</p> <p>No documentation was provided that addresses that the Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270.</p> <p>Additionally, the documents submitted do not address all provider types found in this requirement.</p> <p><u>Recommendation for PHP</u> The plan needs to add language to its policies and procedures that addresses the specific provider types denoted in this requirement and the plan also needs to address the willing provider statute detailed in 907 KAR 1:672 and KRS 304.17A-270.</p>	<p><u>Passport Response:</u> Passport acknowledges the recommendations.</p>



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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.				
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.		Full	This requirement is addressed in the Provider Manual. The Provider Manual states the application should include a copy of CLIA.	
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.		Substantial	This requirement is addressed in CR 6.01 Organizational Provider Credentialing/ Recredentialing Policy and Procedure. The Provider Manual does not address this requirement. Recommendation for PHP The plan should include this requirement in its Provider Manual.	Passport Response: Passport agrees with the recommendation.



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If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.		Full	This requirement is addressed in CO8 Program Integrity Policy.	
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.		Non-Compliance	No documentation was provided that stated that the plan must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor. Recommendation for PHP The plan needs to add this contractual language to its policies and procedures.	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by developing Policy PC 85.0, Electronic Health Record Incentive Funds.  PC 85 - Electronic Health Record Incentiv
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a format specified by the Department report all out-of-network utilization by Members.		Full	This requirement is addressed in PC 83.0 Provider Contracting and Enrollment. P/P CCR 21.0 Non-Participating Provider Claims Set-Up submitted and defines the method by which claims are processed for providers who are not contracted with PHP, but are providing services to plan members.	
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-		Non-Compliance	Documentation provided does not address the requirement that the contractor may enroll providers in their network who are not participating in the KY Medicaid Program as	Passport Response: Passport Health Plan has acted upon IPRO's recommendations by updating the language in policy CR 1.01, Practitioner Credentialing



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<p>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>long as the providers meet the credentialing standards described in the Credentialing and Re-Credentialing of the contract with the state and are eligible to enroll with the KY Medicaid Program.</p> <p>Additionally, no documentation was provided that detailed that a provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process.</p> <p>Recommendation for PHP The plan should add this contractual language to its policies and procedures as well as to the Provider Manual.</p>	<p>Policy and Procedures and CR 4.01, Practitioner Recredentialing Policy and Procedure to include the recommended information. These Policies are pending internal Passport approval.</p> <p><u>Comment:</u> Passport Health Plan should submit the revised P/Ps to DMS once approved.</p>
28.4 Enrolling Current Medicaid Providers				
<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>	<p>;</p>	<p>Full</p>	<p>This requirement is addressed in CR13.0 Provider Enrollment with the Department for Medicaid Services.</p>	

Comment [SP1]: Identify whose comment this is.



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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.				
28.5 Enrolling New Providers and Providers not Participating in Medicaid				
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid Provider number.		Full	P/P CR 13.0 Provider Enrollment with the Department for Medicaid Services addresses this requirement.	
28.6 Termination of Network Providers or Subcontractors				
Any Provider or Subcontractor who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program		Full	P/P CR 1.01 Practitioner Credentialing addresses this requirement.	



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shall be terminated from participation.				
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.		Full	P/P CR 1.01 Practitioner Credentialing addresses this requirement. Onsite, the plan provided evidence of the use of the PTR as referenced in Appendix K of the contract.	



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	76	2	0	2
Total Points	228	4	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		2.90		

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’ 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 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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27.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement. PCP Contract Statewide addresses 24/7 care.	
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement. 2013 QI Program Description also addresses this requirement.	
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's				



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policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
D. Discussing Advance Medical Directives with all Members as appropriate;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
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		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	



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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:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
B. Unacceptable				
(1) Office phone is only answered during office hours;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
(2) Office phone is answered after hours by a recording that tells Members to leave a message;		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
(3) Office phone is answered after hours by a recording		Full	2013 Provider Manual; The Role of the Primary	



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that directs Members to go to the emergency room for any services needed; and			Care Provider addresses this requirement.	
(4) Returning after-hours calls outside of thirty (30) minutes.		Full	2013 Provider Manual; The Role of the Primary Care Provider addresses this requirement.	
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all Covered Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of Medically Necessary services.		Substantial	<p>PCP Contract State Wide addresses the requirement for Covered services in terms of timeliness, amount, duration, and scope.</p> <p>Requirement met per PCP Agreement sections: 3.8 Provider shall not discriminate based upon source of payment. 3.11 Appropriate and adequate medical care. 3.5 Basic health services with same standard of care as community providers. However, language does not specify that "no incentive is provided...to providers for the withholding from members of medically necessary services."</p> <p>Recommendation for PHP Add language regarding "no incentive... to withhold services" to relevant policy/procedure document.</p>	Passport Response: Passport agrees with the recommendation.
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.		Full	PR 13.0 addresses access and appointment availability standards, e.g., rural hospital within 60 miles or 60 minutes; Access and Availability reports provided (Managed Care Accessibility Analysis) document that this requirement is met.	



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Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:		Full	P/P PR 13.0 Access and Appointment Availability Standards address this requirement.	
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.		Full	P/P PR 13.0 Access and Appointment Availability Standards address this requirement. Also located in Provider Manual.	
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.		Full	P/P PR 13.0 Access and Appointment Availability Standards address this requirement.	
C. Immediate treatment for Emergency Care at a health		Full	P/P PR 13.0 Access and Appointment	



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facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.			Availability Standards address this requirement.	
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.		Full	P/P PR 13.0 Access and Appointment Availability Standards address this requirement.	
E. General dental services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.		Full	Access standard documented in PR 13.0, Managed Care Accessibility Analysis: 1 in 30 miles; 100% of members with access.	
F. General vision, laboratory and radiology services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.		Full	P/P PR 13.0 addresses Appointment and waiting time requirement. Access standard documented in PR 13.0, Managed Care Accessibility Analysis: 1 in 30 miles; 100% of members with access.	
G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.		Full	Access standard documented in PR 13.0, Managed Care Accessibility Analysis: 1 in 30 miles; 100% of members with access.	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;		Full	PC 83.0 Provider contracting and enrollment	



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			addresses consistent process for contracting with providers inside and outside of KY. University of Kentucky Hospital agreement documents enrollment of a teaching hospital.	
B. FQHCs and rural health clinics;		Full	Provider listing report documents FQH provider system enrollment.	
C. The Kentucky Commission for Children with Special Health Care Needs; and		Full	PHP Commission for Children Report documents PHP members enrolled in this program.	
D. Community Mental Health Centers		Full	PR13.0 Access and Appointment Availability Standards and PC 84.0 Behavioral Health Provider Contracting and Enrollment both address CMHCs.	
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.		Substantial	Policy CR 21.0 Non-Participating Provider Claims Set-Up addresses this requirement. Although this policy does not specifically document submission to the Department, Plan described relevant collaboration with State. <u>Recommendation for PHP</u> The policy should be revised to include submission to the Department.	<u>Passport Response:</u> Passport agrees with the recommendation.
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.				



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Such participation agreements shall include the following provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.		Full	DPH Passport Agreement addresses this requirement. Document located under Medical Records.	
B. Provide reimbursement at rates commensurate with those provided under Medicare.		Full	Addressed in DPH Passport Agreement, PCP Contract State Wide and Specialist Contract State Wide state reimbursement rate shall be at a rate equivalent to the Medicare rate.	
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.		Full	Jewish Hospital is a provider of indigent care, and is listed in the "Facets" system as a participating hospital; therefore, there is documentation that this requirement is met.	
The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.		Full	The Managed Care Accessibility Analysis documents this requirement; for example, addresses that there be sufficient numbers of the following provider types that traditionally provide a significant level of care to Medicaid members: PCP, hospital, pharmacy, dental.	
28.8 Program Mapping				



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The Contractor shall initially submit a series of maps and charts in a format prescribed by the Department that describes the Contractor's Provider Network, as set forth below. The use of computer-generated maps is preferred. Maps shall include geographic detail including highways, major streets and the boundaries of the Contractor's network. In addition to the maps and charts, the Contractor shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care.		Full	<p>PP Reports 7/30/13 Report 12A MAPS address this requirement. Maps include highways and interstates.</p> <p><u>Provider designations included:</u> PCPs and PCP centers Dentists Specialty providers Non-physician providers Hospitals Urgent care centers Local health departments FQHC and Rural Health Pharmacies Family Planning clinics Significant Traditional Providers Maternity Care Physicians Vision Community Health Centers</p> <p>PP Reports 7/30/13 Report 12A Analysis addresses this requirement.</p> <p>LOB1300 Passport Annual Report addresses the required analysis.</p>	
Maps shall include the location of all categories of Providers or provider sites as follows:				
A. Primary Care Providers (designated by a "P")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	



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B. Primary Care Centers, non FQHC and RHC (designated by a "C")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
C. Dentists (designated by a "D")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
D. Other Specialty Providers (designated by a "S")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A")		Substantial	PP Reports 7/30/13 Report 12A MAPS address this requirement except Nurse Practitioners, Nurse Mid-wives, and PA were not specified. <u>Recommendation for PHP</u> Reports should include designated non-physician providers by type.	<u>Passport Response:</u> Passport agrees with the recommendation.
F. Hospitals (designated by a "H")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
G. After hours Urgent Care Centers (designated by a "U")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
H. Local health departments (designated by a "L")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
J. Pharmacies (designated by a "X")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
K. Family Planning Clinics (designated by an "Z")		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	



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L. Significant traditional Providers (designated by an “*”)		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
M. Maternity Care Physicians (designated by a “ ^o ”)		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
N. Vision Providers (designated by a “V”)		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
O. Community Mental Health Centers (designated by a “M”)		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
The Contractor shall update these maps to reflect changes in the Contractor’s Network on an annual basis, or upon request by the Department.		Full	PP Reports 7/30/13 Report 12A MAPS address this requirement.	
28.9 Expansion and/or Changes in the Network				
If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify the Department of this situation and submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time-frames to correct the deficiency.		Full	P/P PR 20.0 Network Adequacy-Provider Recruitment addresses this requirement.	
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to		Full	P/P PR 20.0 Network Adequacy-Provider Recruitment addresses this requirement.	



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determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.				
30.1 Medicaid Covered Services				
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.		Full	PCP Contract State Wide addresses this requirement.	
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.		Full	P/P CC 20.01 Transition and Continuity of Care addresses continuity of care for members whose benefits are exhausted. Provider Manual; Role of the PCP hold the provider responsible for maintaining continuity of the Member's health care. Provider contract, 6.3, addresses this requirement: Provider agrees to forward member medical records to the member's new PCP within 10 days of member request due to termination, transfer, or otherwise.	
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				



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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 Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.		Full	Requirement met per Policy ME 13.0 addresses referrals to HANDS, WIC, and Healthy Start.	
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).		Full	The Provider Manual addresses this requirement.	



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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.				
The Contractor shall not prohibit or restrict a Provider from advising a beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.		Full	The Provider Manual addresses this requirement.	
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.		Full	The Provider Manual addresses this requirement.	
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.		Full	The Provider Manual addresses this requirement.	
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post		Full	P/P PR 13.0 Access and Appointment Availability Standards address this requirement.	



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Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).				
32.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in 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.		Full	<p>P/P PR 20.0 Network Adequacy-Provider Recruitment addresses this requirement.</p> <p>Provider Manual addresses this requirement as: Emergency care is also a covered benefit for members when they are out of the service area. A referral or PA is not required for out-of-service-area emergency care in the ER.</p> <p>Policy CR 21.0 Non-participating provider claims set-up addresses the requirement of non-emergent services accessed out of area.</p>	
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.		Non-Compliance	<p>At on-site interview, the Plan stated that payment would never exceed 90% of the DMS fee schedule, and that this limit was stated in policy CR 21.0 Non-Participating Provider Claims Set-Up; however, the policy document provided did not address this limit.</p> <p>Recommendation for PHP Policy should be revised to include reference to the Medicaid fee-for-service rate.</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation by adding language to include reference to the Medicaid fee-for-service rate.</p> <p>CR 21.0, Non-Participating Provider Claims Set-Up, see page 2, 6 B.</p> <div style="text-align: center;">  CR 21 0 - Non Participating Provider </div>
30.2 Direct Access Services				



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The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.		Full	P/P PR 20.0 Network Adequacy-Provider Recruitment addresses this requirement.	
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;		Full	Provider Manual addresses this requirement.	
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;		Full	Provider Manual addresses this requirement.	
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;		Full	Provider Manual addresses this requirement.	
D. Maternity care for Members under 18 years of age;		Full	Provider Manual addresses this requirement.	
E. Immunizations to Members under 21 years of age;		Full	Provider Manual addresses this requirement.	
F. Sexually transmitted disease screening, evaluation and		Full	Provider Manual addresses this requirement.	



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



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	73	4	0	1
Total Points	219	8	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.91		

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’ 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:

- 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



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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
- 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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20.6 Utilization Management				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.		Full	The requirement is addressed in the PHP UM Program Description.	
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.		Full	The requirement is addressed in the PHP UM Program Description. The Program Description contains an outline of general processes for delegated entities and lists subcontractors with their general areas of delegation.	
The description shall include the scope of the program;		Full	The requirement is addressed in the PHP UM Program Description.	
the processes and information sources used to determine service coverage;		Full	The requirement is addressed in the PHP UM Program Description.	
clinical necessity, appropriateness and effectiveness;		Full	The requirement is addressed in the PHP UM Program Description.	
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;		Minimal	<p>The UM Program Description referred to policies and procedures regarding Care Coordination and Discharge Criteria.</p> <p>Cultural Competence of Care Delivery is only addressed by a statement of compliance with Title VI of the Civil Rights Act of 1964 regarding translation of materials.</p> <p>Site of Services and Triage Decisions were not found within the documentation.</p> <p>Policy language regarding Levels of Care is</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation and has revised the policies listed below to reflect how it handles Care Coordination, Discharge Criteria, Site of Service, Levels of Care, Triage Decisions and Cultural Competence:</p> <p>Care Coordination - UM 35.00 Review Process Policy and Procedure revised: See # 1A Care Coordination Also in UM / Clinical Programs Description 1G Page 21</p>



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			<p>mentioned only in conjunction with transitioning a Member to an alternate level of care. No clear definition or procedure given specifically for Levels of Care.</p> <p><u>Recommendation for PHP</u> The plan needs to fully develop in its policies and procedures how it handles care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery.</p>	<p> UM 35 00 Review Process.docx</p> <p> 2014 Utilization Mng and Clinical Programs</p> <p>Discharge Criteria - Had existing Policy and Procedure UM 9.01 Discharge Planning Also added to UM 35.00 Review Process 1E DC planning Also in UM / Clinical Programs Description 1F Page 21</p> <p> UM 9.01 Discharge Planning.docx</p> <p>Sites of Service - UM 35.00 Review Process Policy and Procedure revised: See # 1B labeled Sites of Service Also added to UM / Clinical Programs Description 1D Page 19</p> <p>Levels of Care - UM 35.00 Review Process Policy and Procedure revised: See # 1C labeled 1C Level of Care</p>



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				<p>Also added to UM / Clinical Programs Description 1E Page 19</p> <p>Triage Decisions - UM 35.00 Review Process Policy and Procedure revised: See 1D Triage</p> <p>Also added to UM / Clinical Programs Description 1C Page 19</p> <p>Cultural competence of care delivery New Desk Top Procedure created – Cultural Competence Also added to UM / Clinical Programs Description 1B Page 11</p> <p style="text-align: center;"> Cultural Competence.docx</p>
processes to review, approve, and deny services as needed.		Full	This requirement is addressed in the 2013 PHP Utilization Management Program Description.	
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.		Full	<p>The requirement is addressed in the 2013 PHP Utilization Management Program Description.</p> <p>The 2012 UM Program Evaluation also addresses this requirement.</p>	
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director or the QI Committee.		Full	This requirement is addressed in the PHP UM Program Description which states that “any modifications to the Utilization Management Program based upon the annual Utilization Management Program Evaluation shall be	



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			<p>reviewed and approved by the Medical Director or the QI Committee."</p> <p>The 2012 UM Program Description states, "An evaluation of the Utilization Management Program is conducted annually."</p> <p>Onsite evidence of annual review was produced.</p>	
The Contractor shall adopt national recognized standards and criteria which shall be approved by the Department.		Full	This requirement is addressed in the 2013 Clinical Programs Description which states that "InterQual™ Guidelines is the clinical decision support tool, approved and recommended for use by DMS, that is utilized by Passport for adult and pediatric services; criteria that supports clinical decision-making, reviewer consistency, efficient operations and reporting."	
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.		Full	This requirement is addressed in the 2013 PHP Utilization Management Program Description.	
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.		Full	The requirement is addressed in the 2013 PHP Utilization Management Program Description.	
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.		Full	This requirement is addressed in the 2013 PHP Utilization Management Program Description which states that clinical information and physician input are included in the criteria determination.	



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The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.		Full	This requirement is addressed in the 2013 Clinical Programs Description. <u>UM File Review</u> 10 of 10 files reviewed showed evidence that the reviewer is a health care professional with appropriate clinical expertise.	
The reason for the denial shall be cited.		Full	The requirement is addressed in the 2013 PHP Utilization Management Program Description. <u>UM File Review</u> 10 of 10 files reviewed contained a reason for the denial.	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.		Full	The requirement is addressed in the 2013 PHP Utilization Management Program Description.	
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.		Full	The requirement is addressed in the 2013 PHP Utilization Management Program Description which states "The review completion time for Inpatient & Outpatient Urgent review requests is one (1) business day," as compared to non-urgent requests, which are two (2) business days. <u>UM File Review</u> Within the file sample review, no file contained cause for an expedited review. All other files met the timeliness standard. Recommendation for PHP The plan should make certain that when it time	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by revising the following policies to reflect that when it time stamps documents, the date on the time stamp is legible. Added language to the following: CP 5.14 Prov Admin Appeal Page 3 - # 14 CP 5.12 Prov Post Service Appeal Page 3 # 15 CP 5.20 Member Appeals – Page 7 UM 35.00 Review Process – See 2A Date Stamp



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			stamps documents that the date on the time stamp is legible.	 CP 5 14 Prov Admin Appeal 1272014.docx <hr/>  CP 5 12 Prov Post Service Medical Appea <hr/>  CP 5 20 Member Appeals with 2013 DM <hr/>  UM 35 00 Review Process.docx
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.		Non-Compliance	Documentation was not provided that shows that the plan submits its request to change any prior authorization requirement to DMS for review. Recommendation for PHP A policy/procedure should be developed addressing the requirement that the plan submit all requests to change any prior authorization to the Department for review and keep a copy of the documentation for its files.	Passport Response: Passport Health Plan has acted upon IPRO's recommendations by developing a New Desk Top Procedure: Utilization Management Program Modifications Also added to UM / Clinical Programs Description 1H Page 24  Utilization Management Program



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				 2014 Utilization Mng and Clinical Programs
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.		Full	The 2012 UM Program Evaluation shows that the subcontractors are annually evaluated for consistency of review criteria and that PHP requires its subcontractors to keep policies and procedures regarding consistent application of review criteria.	
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within two working days of providing notification of a decision if the decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.		Full	This requirement is addressed in 2013 PHP Utilization Management Program Description. <u>UM File Review</u> All files reviewed met the two day timeliness requirement. <u>Recommendation for PHP</u> The plan should make certain that when it time stamps documents that the date on the time stamp is legible.	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by adding language to the following: CP 5.14 Prov Admin Appeal Page 3 - # 14 CP 5.12 Prov Post Service Appeal Page 3 # 15 CP 5.20 Member Appeals – Page 7 UM 35.00 Review Process – See 2A Date Stamp <div style="text-align: center;">  CP 5 14 Prov Admin Appeal 1272014.docx </div> <hr/> <div style="text-align: center;">  CP 5 12 Prov Post Service Medical Appea </div>



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				 CP 5 20 Member Appeals with 2013 DM <hr/>  UM 35 00 Review Process.docx
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.		Full	This requirement is addressed in Policy UM 9.01 Discharge Planning which gives the procedure/method to ensure continuity of care in regard to discharge planning.	
E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.		Substantial	<p>The PHP UM Program Description discusses Outpatient Prior Authorization. No documentation was provided that mentions how prior authorization data will be incorporated into PHP's overall Quality Improvement Plan. Prior authorization data is addressed in the QI Work Plan and annual QI Program Evaluation.</p> <p>Recommendation for PHP The plan needs to address in policies and procedures how prior authorization data will be incorporated into the overall QI Plan.</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation by adding language to UM 1.01 Utilization Management Program – Letter I</p> <p>Also added to UM / Clinical Programs Description 11 page 24</p> <p style="text-align: center;">  UM 1.01 Utilization Management Program </p>



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Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.		Full	The requirement is addressed in PHP's UM Program Description.	
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.		Full	The requirement is addressed in the 2013 PHP Utilization Management 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.		Full	The requirement is addressed in the 2013 PHP Utilization Management Program Description.	
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.		Full	The requirement is addressed in the 2012 PHP Provider Satisfaction Survey Results and in the 2013 CAHPS Report.	
The UM program will be evaluated by DMS on an annual basis.		Substantial	The 2012 UM Program Evaluation states that "an evaluation of the Utilization Management Program is conducted annually". It does not reference submission to DMS. Recommendation for PHP The plan should add language into its policies	Passport Response: Passport Health Plan has acted upon IPRO's recommendation by adding language to UM 1.01 Utilization Management Program – Letter H



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			and procedures that the UM Program Evaluation is submitted to DMS annually.	 UM 1.01 Utilization Management Program
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall give the Member written notice that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:		Full	The requirement is addressed in P/P UM 11.01 Denial of Services Based on Lack of Medical Necessity. This requirement is communicated to the member in the Member Handbook.	
(a) The action the Contractor has taken or intends to take;		Full	The requirement is addressed in P/P UM 11.01. <u>UM File Review</u> 10/10 files were in full compliance.	
(b) The reasons for the action;		Full	The requirement is addressed in P/P UM 11.01. <u>UM File Review</u> 10/10 files were in full compliance.	
(c) The Member's right to appeal;		Full	The requirement is addressed in P/P UM 11.01. <u>UM File Review</u> 10/10 files were in full compliance.	
(d) The Member's right to request a State hearing;		Full	The requirement is addressed in P/P UM 11.01. <u>UM File Review</u> 10/10 files were in full compliance.	



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(e) Procedures for exercising Member's rights to appeal or file a grievance;		Full	The requirement is addressed in P/P UM 11.01. The PHP UM Program Description addressed the procedure for filing a grievance. <u>UM File Review</u> 10/10 files compliant.	
(f) Circumstances under which expedited resolution is available and how to request it; and		Full	The requirement is addressed in P/P UM 11.01.	
(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.		Full	The requirement is addressed in P/P UM 11.01. <u>UM File Review</u> All files were in full compliance. All files review advised the members of their right to have benefits continue pending the resolution of the Appeal. The files also all contained how to request the continuation of benefits and the circumstances under which the member may be required to pay for the costs of those services.	
The Contractor must give notice at least: A. Ten (10) days before the date of Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.		Full	The requirement is addressed in P/P UM 11.01.	
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;		Full	The requirement is addressed in P/P UM 11.01.	
2. A signed written Member statement requesting		Full	The requirement is addressed in P/P UM 11.01.	



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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 he is ineligible for further services;		Full	The requirement is addressed in P/P UM 11.01.	
4. The Member's address is unknown and mail directed to him has no forwarding address;		Full	The requirement is addressed in P/P UM 11.01.	
5. The Member has been accepted for Medicaid services by another local jurisdiction;		Full	The requirement is addressed in P/P UM 11.01.	
6. The Member's physician prescribes the change in the level of medical care;		Full	The requirement is addressed in P/P UM 11.01.	
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;		Full	The requirement is addressed in P/P UM 11.01.	
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.		Full	The requirement is addressed in P/P UM 11.01.	
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.		Full	This requirement is addressed in the P/P UM 11.01.	
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		Full	The requirement is addressed in P/P UM 11.01.	



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

State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.				
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.		Full	The requirement is addressed in P/P UM 11.01.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) working days after receipt of the request for service.		Full	The requirement is addressed in P/P UM 11.01.	
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.		Full	This requirement is addressed in P/P 11.01 and in the 2013 PHP UM Program Description.	



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	45	2	1	1
Total Points	135	4	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.86		

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’ 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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36. Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix M, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. This plan shall include, at a minimum:		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit, the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit, the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit and the Program Integrity Plan 2013.	
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit, the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. This requirement is implemented through	



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			mandatory training that includes federal and state guidelines and department standards; all employees attend the training at the beginning of their employment, annually and as needed. Providers are educated twice yearly through articles in the provider newsletter and on the web site while members are educated via the Member Handbook and member newsletters.	
D. Effective lines of communication between the compliance officer and the organization's employees;		Full	This requirement is addressed in the Program Integrity Plan 2013. This requirement is implemented through handouts and emails that alert employees of messages from the compliance officer. Having all PHP's employees located within the same building proves an asset to effective communication.	
E. Enforcement of standards through disciplinary guidelines;		Full	This requirement is addressed in CO 37 Corporate Fraud and Misconduct Investigation Policy. This requirement is implemented and communicated to employees through annual and ad hoc training given by the compliance officer.	
F. Provision for internal monitoring and auditing of the member and provider;		Full	This requirement is addressed in the Program Integrity Plan 2013. This requirement is communicated to the providers in the Provider Manual and	



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			communicated to the members in the Member Handbook.	
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;		Full	This requirement is addressed in the Program Integrity Plan 2013 and in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. This requirement is communicated through the contractors' contract and implemented by the use of internal monitoring and auditing of the contractor and subcontractors.	
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit, the Program Integrity Plan 2013 and in CO 33.0 Subcontractor Oversight. Additionally, this requirement is addressed and communicated to employees through IA 4.02 Internal Auditing of Corrective Actions.	
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. Employee training instructs employees to have close communication with the department and comply with requests to supply documentation and records.	
J. Contractor shall create an account receivables process to collect outstanding debt from members		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse -	



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or providers; and provide monthly reports of activity and collections to the department;			Program Integrity Unit and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
K. Contractor shall provide procedures for appeal process;		Full	This requirement is addressed in the Program Integrity Plan 2013, CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. The process is communicated to providers in the Provider Manual and to members in the Member Handbook.	
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;		Full	This requirement is addressed in the Program Integrity Plan 2013, CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. The random sampling is conducted by Member Services with the MCO reporting that issues occur infrequently. Issues detected are communicated to the Department.	
M. Contractor shall create a process for card sharing cases;		Full	This requirement is addressed in the Program Integrity Plan 2013 and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
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		Full	This requirement is addressed in the Program Integrity Plan 2013. PHP runs algorithms on claims data and	



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overpayments collected;			reports findings, and actions taken, to the Department.	
O. Contractor shall follow cases from the time they are opened until they are closed; and		Full	This requirement is addressed in the Program Integrity Plan 2013. Cases are closely monitored from inception to completion. Implementation of this requirement extends beyond the closing of a case. The plan will revisit closed cases based upon new information obtained at state meetings.	
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit and in the Program Integrity Plan 2013. This requirement is communicated to employees through handouts, emails and postings.	
The plan shall be made available to the Department for review and approval.		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
10.1 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic		Full	This requirement is addressed in CO 8.2.13 FWA – PIU.	



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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 identified by the Department.			The Compliance personnel at PHP as well as Associate General Counsel maintain current knowledge of Federal and State legislation and regulations and oversee and implement the communication of these requirements to the employees through training and regular communication with employees.	
Q, A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid services.		Full	This requirement is addressed in the Program Integrity Plan 2013. Program Integrity personnel coordinate, oversee and implement the PI program to identify and reduce fraud, waste and abuse.	
37.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. This requirement is communicated to finance, the Department and CMS at the time of each annual audit, at the time each Medicaid survey is conducted, prior to the initiation of a new contract with the department, upon any change in operations that affects a disclosure report or within thirty-five days following the	



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(5) within thirty-five (35) days following the date of each written request for such information:			<p>date of each written request for information.</p> <p>PHP screens current and new employees, subcontractors, and vendors against the OIG's List of Individuals/Entities Excluded from Federal Programs twice yearly; the Secretary of State website is also checked twice yearly to ensure all vendors and subcontractors are registered.</p> <p>A total of 9 entities were reviewed and findings are noted below:</p> <p>PHP University Medical Center – no officers listed on excluded lists</p> <p>Perform Rx –no officers listed on excluded lists</p> <p>Block Vision – no officers listed on excluded lists</p> <p>AmeriHealth HMO – no officers listed on excluded lists</p> <p>AmeriHealth Caritas HP - no officers listed on excluded lists</p> <p>Emdeon TC3 - no officers listed on excluded lists</p> <p>Beacon Health Strategies - no officers listed on excluded lists</p>	



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			Avesis Third Party Administrators - no officers listed on excluded lists MedSolutions - no officers listed on excluded lists	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this requirement and for communicating any findings to the department.	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this requirement and for communicating any findings to the department.	
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than \$250,000 during the immediately preceding twelve-month period;		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this requirement and for communicating any findings to the department.	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this	



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			requirement and for communicating any findings to the department.	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this requirement and for communicating any findings to the department.	
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this requirement and for communicating any findings to the department.	
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.		Full	This requirement is addressed in CO 10 Ownership & Financial Disclosure. The MCO's program integrity department is responsible for the implementation of this requirement and for communicating any findings to the department.	
State Contract, Appendix M				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				



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A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit. The written policies, procedures and standards of conduct are communicated to the employees through annual and ad hoc training.	
B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit. This requirement is communicated to the employees through training and PHP procedural language.	
C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit. Staff members, including a compliance officer as well as auditors and clinical staff, in the PIU are able to conduct the functions specified in the contract on a continuous and ongoing basis.	
D. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse and in the Program Integrity Plan 2013.	
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste	



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			Abuse and in the Program Integrity Plan 2013.	
(2) High dollar amount of potential overpayment; or		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse and in the Program Integrity Plan 2013.	
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse and in the Program Integrity Plan 2013.	
E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. This requirement is addressed through the use of employee training and communicated to the employees by the compliance manager.	
F. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.		Full	This requirement is addressed in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit and in the Program Integrity Plan 2013. This requirement is communicated to employees through handouts, emails and postings.	
FUNCTION: The Contractor shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:		Full	This requirement is addressed in the Program Integrity Plan 2013. PHP has established a PIU to identify and refer to the department any suspected fraud	



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			or abuse of members or providers.	
A. Preventing Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of member and provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse, the Program Integrity Plan 2013 and in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit. The PIU is responsible for the recoupment of overpayments, changes to policy, dispute resolution meetings and 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;		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse, the Program Integrity Plan 2013 and in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit. PHP runs algorithms on claims data and reports findings, and actions taken, to the Department.	
C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse, the Program Integrity Plan 2013 and in CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	
D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	



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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;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	
F. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	
G. Making and receiving recommendations to enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse and CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	
H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
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;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. Quarterly reports are provided to the department on the activity related to internal monitoring and auditing.	
J. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
K. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	



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to the department.			Monthly reports of reporting and collections are provided 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;		Full	This requirement is addressed in CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
B. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG;		Full	This requirement is addressed in the Program Integrity Plan 2013 and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. Post-payment audits of provider billings and investigations pertaining to payment errors are reported to the department and OIG.	
C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;		Full	This requirement is addressed in the Program Integrity Plan 2013 and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
D. Maintain locally cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;		Full	This requirement is addressed in the Program Integrity Plan 2013 and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. The cases under investigation are kept onsite at the plan and are producible to the department and/or OIG upon demand.	
E. Designate a contact person to work with investigators and attorneys from the Department and OIG;		Full	This requirement is addressed in the Program Integrity Plan 2013 and in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. Members of the PIU, the compliance	



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			department as well as Associate General Counsel are available 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;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
G. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. The random sampling provided by this requirement is conducted by Member Services and verified with the member.	
H. Run algorithms on claims data and develop a process and report quarterly to the department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. PHP runs algorithms on claims data and reports findings, and actions taken, to the Department.	
I. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity and CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	
J. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	



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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;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
L. Have a method for recovering overpayments from providers;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
M. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
N. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations; and		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 06.18.2013 Fraud, Waste and Abuse - Program Integrity Unit.	
O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.		Full	This requirement is addressed in the Program Integrity Plan 2013.	
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services and OIG.		Full	This requirement is addressed in the Program Integrity Plan 2013, CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	



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COMPLAINT SYSTEM: The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process shall contain the following:				
A. Upon receipt of a complaint or other indication of potential fraud or abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
C. Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
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;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
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		Full	This requirement is addressed in the Program Integrity Plan 2013.	



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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;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
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 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		Full	This requirement is addressed in the Program	



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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;			Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
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:		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
(1) Name and address of subject,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the name and address of the subject.	
(2) Medicaid identification number,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the Medicaid identification number.	
(3) Source of complaint,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u>	



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			Of the 10 files reviewed, all 10 contained the source of the complaint.	
(4) The complaint/allegation,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the complaint/allegation.	
(5) Date assigned to the investigator,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the date of assignment to the investigator.	
(6) Name of investigator,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the name of the investigator.	
(7) Date of completion,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	



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			<u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the date of completion.	
(8) Methodology used during investigation,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the methodology used during the investigation.	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained the facts discovered by the investigation as well as the full case report and supporting documentation.	
(10) All exhibits or supporting documentation,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained exhibits or supporting documentation.	
(11) Recommendations as considered necessary, for administrative action or policy revision,		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013	



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			Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained policy personnel credentials and their comments on the case as applicable.	
(12) Overpayment identified, if any, and recommendation concerning collection.		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. <u>Program Integrity File Review</u> Of the 10 files reviewed, all 10 contained information regarding whether or not overpayment was identified. A recommendation concerning collection was not applicable for the given file sample.	
M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse. A quarterly member and provider status report of all cases including actions taken to implement recommendations and collections of overpayments is provided to the Department and OIG in the form on a spreadsheet. The MCO provided quarterly MCO reports: 72, 75, 76 and 77.	
N. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013	



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particular complaint or grievance process or the status of a specific recoupment; and			Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
O. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 8 9.24.2013 Program Integrity - Prevention, Detection & Investigation of Fraud Waste Abuse.	
REPORTING: The Contractor's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure. If any internal component of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG.		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(1) PIU Case number;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	



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(2) OIG Case number;		Not Applicable	<p>This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.</p> <p>MCO Quarterly Reports 72, 76 and 77 were provided. DMS template reports for Reports 76 and 77 do not include this requirement.</p> <p>Recommendation for DMS DMS should consider including OIG case number in the template reports for Reports 76 and 77.</p>	
(3) Provider/Member name;		Full	<p>This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.</p> <p>MCO Quarterly Reports 72, 76 and 77 were provided.</p>	
(4) Provider/Member number;		Full	<p>This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.</p> <p>MCO Quarterly Reports 72, 76 and 77 were provided.</p>	
(5) Date complaint received by Contractor;		Full	<p>This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.</p> <p>MCO Quarterly Reports 72, 76 and 77 were provided.</p>	
(6) Source of complaint, unless the complainant		Full	<p>This requirement is addressed in CO 7</p>	



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prefers to remain anonymous;			6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(7) Date opened;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(8) Summary of complaint;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);		Not Applicable	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided. DMS template reports for Reports 76 and 77 do not include this requirement. Recommendation for DMS DMS should consider including this requirement in Reports 76 and 77.	
(10) PIU action taken (only provide the most current update);		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	



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			MCO Quarterly Reports 72, 76 and 77 were provided.	
(11) Amount of overpayment (if any);		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(12) Administrative actions taken to resolve findings of completed cases including the following information:		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(a) The overpayment required to be repaid and overpayment collected to date;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(b) Describe sanctions/withholds applied to Providers/Members, if any;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(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		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	



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they have occurred;			MCO Quarterly Reports 72, 76 and 77 were provided.	
(d) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
(e) Make MIS system edit and audit recommendations as applicable.		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. MCO Quarterly Reports 72, 76 and 77 were provided.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, keep and maintain records including, but not limited to, ownership disclosure for all providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. The plan reports that it keeps and maintains records indefinitely.	
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud,	



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			Waste and Abuse - Program Integrity. All data is stored and maintained on premises.	
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
E. Produce records in electronic format for review and manipulation by the Department and the OIG;		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. Designated department staff have read access to all data in the plan's MIS systems.	
G. Provide all contracted rates for providers upon request.		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
The Contractor's PIU shall have access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	
The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or		Full	This requirement is addressed in the Program Integrity Plan 2013.	



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abuse cases.			Members of the PIU, the compliance department as well as Associate General Counsel are available to work with investigators and attorneys from the department, US Attorney's Office and OIG.	
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.		Full	This requirement is addressed in CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity. The Plan reports that there were no instances in the review period where no action was taken towards the collection of overpayment in which the Commonwealth intervened.	
The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover.		Full	This requirement is addressed in the Program Integrity Plan 2013 and CO 7 6.18.2013 Fraud, Waste and Abuse - Program Integrity.	



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	116	0	0	0
Total Points	348			

Overall Compliance Determination:

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

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

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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32.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)				
<p>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.</p>		Full	<p>P/P EP 17.0, the 2013 EPSDT Program Description, the Member Handbook, and the Provider Manual and training materials all indicate that PHP members from birth to 21 years of age are automatically eligible for the EPSDT program, and members may opt-out of the outreach component of the program. P/P EP 17.0 states that members that opt-out remain eligible for services.</p> <p>The plan submitted CMS Form 416 reports as evidence of quarterly and annual submission of EPSDT screening and participation rates. MCO Report #38 provides a monthly report to DMS of claims paid for EPSDT Special Services.</p> <p>The plan reported an EPSDT screening rate of 100% for FFY 2013. EPSDT Participation was 77% which was below the goal of 80%.</p> <p>PHP submitted documentation of the Data Analysis and Reporting Team (DART) process for calculation of EPSDT screening and participation rates as per CMS form 416 and state requirements. The plan provided evidence of tracking database for services and also for tracking referrals and receipt of services; plans are underway at the MCO to merge the two systems as per onsite staff.</p>	



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			<p>Recommended screenings and components of age-appropriate screenings are documented in the Provider Manual.</p> <p>Onsite staff provided plan attestations for timely submission of required reports.</p>	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:		Full	<p>P/P EP 17.0 and the 2013 Provider Manual indicate that PCPs that care for children younger than age of 21 years are required to perform EPSDT services. As per P/P EP 17.0, EPSDT services are also provided by Departments of Health.</p> <p>Targeted education on the EPSDT program is outlined for providers in the 2013 Provider Manual, the EPSDT Orientation Packet, New Provider Toolkit, PHP website, face to face office visits by the Provider Network Account Manager, and monthly reports of members due/overdue for screenings.</p> <p>Clinician adherence is reviewed as part of the annual QI evaluation as per the EPSDT Program Description and Provider Manual.</p>	
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034*, and who are supported by adequately equipped offices to perform EPSDT services.		Full	<p>As noted above, all PCPs that care for children younger than 21 years provide EPSDT services, and there is an EPSDT-specific Provider Orientation Kit. The Provider Orientation Kit explains the provider's responsibility with regards to access and availability for EPSDT services,</p>	



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			<p>standards for appointment scheduling and after hours coverage and requirements are outlined in the Provider Manual. Provider trainings occur by multiple methods: Provider Orientation Kit, online materials, Provider Manual, EPSDT Orientation Packet, and onsite visits from Provider Network Account Manager. This Manager also keeps attendance rosters for trainings as per P/P PR58.0. The plan submitted five sign-in sheets for provider trainings that reveal providers from multiple specialties in attendance. Sign in sheets were provided for rural roundtable and primary care workshops, which include EPSDT training as described by onsite staff. The provider newsletter is used to send providers updates to policy changes as per the sample newsletter dated 3/27/13. P/P EP17.0 describes other provider outreach methods including: eNews Alerts, written notice, provider website postings, and provider workshops.</p> <p>The Provider Manual indicates the plan will perform annual audits of claims for EPSDT elements. If deficiencies are discovered, the provider will be educated, re-evaluated, and corrective action will be planned as necessary. Offices are evaluated during onsite provider visits for new providers and if concerns are identified.</p>	



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<p>B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.</p>		Full	<p>Evidence was provided of communication with members regarding EPSDT services, including the Member Handbook, Confirmation Letter, member newsletter 2013 issue 1, PHP SoundCare (on-hold) message, the plan's website, EPSDT brochure 01a-HMHM 11195, quarterly mailings, and telephonic outreach. Distribution of materials at community events and onsite visits throughout the measurement period are activities documented in the annual work plan reports.</p> <p>Documents include information regarding access to services, EPSDT benefits including vision, hearing, dental and mental health services, ages-appropriate preventive health screenings and the value of preventive care, and EPSDT expanded services are described in the Member Handbook.</p> <p>The EPSDT brochure and Member Handbook advise contacting Member Services for assistance with EPSDT services, and accessing care connectors for assistance with accessing services.</p> <p>P/P EP17.0 documents the plan's procedure for identifying members for outreach by telephone then, if unsuccessful, by home visit. The plan provided a screenshot of the EPSDT Call center application tracking database, showing status of screens due,</p>	



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			<p>completed and pending, and outreach. Onsite staff provided referral database information for children requiring referrals for diagnosis or treatment.</p> <p>The work plan and the P/P EP 17.0 documents robust outreach including telephonic outreach, mailings, and home visits through contracted local departments of public health.</p>	
<p>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>		Full	<p>The Member Handbook informs the members and their families about the EPSDT program including, what they should expect from their PCP, the ages of children eligible for services, the types of screenings covered, that the plan's EPSDT team will outreach to them to further educate them about this program, how to opt out of the outreach component of the program while still remaining eligible for screenings and vaccinations, that special services need referral and authorization, and finally, that there is a rewards program for their compliance with check-ups.</p> <p>Information regarding the right to appeal any decision relating to Medicaid services and how to contact member services for assistance is included in the PHP Member Handbook and the Member Newsletter 2013 Issue 1.</p> <p>The EPSDT Program Description and P/P EP</p>	



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			<p>17.0 note automatic enrollment of all children under age 21 into PHP's EPSDT outreach program and the right to refuse participation.</p> <p>Members overdue for screens and/or non-compliant with periodic participation are prioritized for telephonic outreach as per Program Description and P/P EP 17.0, with home visit if telephonic contact is unsuccessful, followed by letter regarding EPSDT services if home visit unsuccessful; a sample notification letter was provided. As per the EPSDT Orientation Packet, the PCP must attempt to contact noncompliant members directly prior to referring the member to the EPSDT outreach team.</p> <p>The letter acknowledging request to withdraw from EPSDT outreach could be interpreted to mean that members are opting out of the EPSDT services rather than outreach program. This was discussed with onsite staff and they will re-assess the withdrawal letter.</p> <p><u>UM File Review</u> Five UM files related to EPSDT (child members) were reviewed. All files were completed timely and were compliant.</p> <p><u>Member Appeal File Review</u> Five appeal files related to EPSDT (child members) were reviewed. All files were</p>	



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			<p>completed timely and were compliant.</p> <p><u>Recommendation for PHP</u> The plan should reassess member withdrawal letter to ensure that it is clear that members are opting out of the plan's outreach program and not EPSDT services.</p>	<p><u>Passport Response:</u> Passport acknowledges the recommendation.</p>
<p>C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.</p>		Substantial	<p>EPSDT screening components are described in the Provider Manual, the EPSDT Orientation Packet, EPSDT Program Description, P/P EP 17.0, and Clinical Practice Guidelines screenshot of the plan's provider website. Members' receipt of screening is tracked by the plan as evidenced by the provided EPSDT Call Center application screenshot, and referrals are tracked as evidenced by NaviNet.</p> <p>The Provider Manual states that the plan will no longer use the state periodicity schedule as a guide to screening and will now use the American Academy of Pediatrics Guidelines for screening interval recommendations. These guidelines are available in the documents listed above. It was discussed with onsite staff that AAP guidelines in provided documents require updating with most recent AAP guidelines.</p> <p>As per the EPSDT Program Description, Provider Manual, and P/P 17.0, providers are sent a monthly report listing members who are due/overdue for recommended</p>	<p><u>Passport Response:</u> Passport acknowledges the recommendation.</p>



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			<p>screenings, as per the EPSDT Call Center application provided; a screen shot of a care gap report was also submitted. The Care Gap Report lists each member and the screenings due, screening expiration date, previous screens performed, and completion date.</p> <p>Eligible members may opt-out with written notice to the plan as per the Member Handbook and P/P EP 17.0. A sample outreach letter was submitted as evidence of further instruction to the member on the process to withdraw from the EPSDT Outreach Program.</p> <p>The plan's EPSDT Program Description includes random claims audit; onsite staff indicated that no audits had been conducted in the review period.</p> <p><u>Recommendation for PHP</u> The plan should ensure that most recent AAP guidelines, including 2014 AAP periodicity schedule, are included in documents.</p> <p>The plan should continue to validate EPSDT services through claims audits as planned and as described in the Program Description.</p>	
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary		Substantial	As per the EPSDT Program Description, providers are notified monthly with a list of	<u>Passport Response:</u> Passport agrees with the recommendation.



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<p>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.</p>			<p>members due/overdue for age-appropriate screens and immunizations. Providers may also be subjected to a random EPSDT claims audit. Provider adherence is evaluated annually by the Manager of Care Coordination, Director of Medical Management, the Chief Medical Officer, with input from the Manager of Quality Improvement.</p> <p>As per the Provider Manual, the plan monitors PCP actions for compliance with PHP and DMS policies. This includes maintaining an up to date medical record for preventive health and well child care visits, the provision of timely reminders to eligible members according to the AAP/Bright Futures Periodicity Schedule and CDC recommended Immunization Schedule.</p> <p>The EPSDT Orientation Packet encourages providers to use NaviNet to obtain patient histories and check for screenings that are due/overdue. NaviNet also provides additional training materials on scheduling EPSDT services. Providers are required to attempt to reach noncompliant members three times before contacting PHP EPSDT Outreach team.</p> <p>The Provider Orientation Kit outlines the provider's responsibility to complete age-appropriate EPSDT services within 30 days of plan enrollment unless the member is up</p>	



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			<p>to date with all screenings and vaccinations. The Kit also describes the Provider Recognition Program which awards financial incentives for performance on EPSDT measures.</p> <p>As noted above, no audits were conducted in the review period.</p> <p><u>Recommendation for PHP</u> The plan should continue to validate EPSDT services through claims audits as planned and as described in the Program Description.</p>	
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034*. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers may provide treatment if the service is not available with the Contractor's Network.		Full	<p>P/P 17.0 indicates that the PCP arranges for diagnosis and treatment. The Provider Manual describes EPSDT Expanded Services as those required to treat conditions detected during an encounter with a health care professional and are eligible for payment under the federal Medicaid program but not currently recognized under the state plan. Providers must submit requests to the plan's UM department for determination of medical necessity and authorizations. Examples of services include expanded dental and vision care, allergy serum and immunizations, health education and other specialty care and supplies. Referrals to a specialist must indicate if the referral is based upon a result from EPSDT screening. This process is reiterated in P/P EP 17.0 and explained in</p>	



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			<p>detail in the EPSDT Orientation Packet.</p> <p>The plan's Desktop Procedure for EPSDT Special Services is intended to ensure compliance with 42 U.S.C. § 1396d(e) and provide any medically necessary health care that falls within the scope of services to a child, even if the service is not available under the State's Medicaid plan to adults. A request for review of services must follow Regulation 907 KAR 11:034. Approval for services is dependent on medical necessity using the criteria outlined in the policy. In accordance with 907 KAR 1:715, school health services are considered medically necessary and do not require authorization.</p> <p>P/P CC 5.04 outlines the plan's method for identifying members with special health care needs. The plan uses the definition of special health care needs as that defined by the federal Maternal and Child Health Bureau. The plan uses the Health Risk Assessment form, diagnosis trigger lists, and utilization management data to identify these members, then refer to the appropriate program for coordination of services and further assistance. An example of an HRA form was submitted.</p> <p>A screenshot of the electronic referral form from NaviNet was submitted to show how providers complete referrals with diagnosis codes required. A paper referral form was</p>	



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			<p>also submitted by the plan.</p> <p>The EPSDT Referral Tracking screenshot shows a flow diagram explaining the plan's process to implement the ability to identify an EPSDT referral and to identify and ensure EPSDT members receive all medically necessary services to be compliant with federal EPSDT program guidelines.</p>	
<p>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.</p>		Full	<p>The Provider Manual, P/P EP 17.0, and the EPSDT Orientation Packet affirm that EPSDT Special/Expanded services, which are services required for conditions identified during screening that are eligible for federal Medicaid but not covered in the Kentucky Medicaid program, are provided by PHP providers and coordinated through PHP's UM department.</p> <p>The Provider Manual describes medically necessary EPSDT services, and refers to UM department for authorization. Referrals to a specialist must indicate if the referral is based upon a result from EPSDT screening.</p> <p>10-24 Behavioral Health Training and PHP to Beacon Referral Form reveals the coordination of mental health services through the vendor, Beacon Health Strategies, LLC.</p> <p>Procedures for authorization for payment for special services are documented in the</p>	



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			<p>Provider Manual and EPSDT provider orientation materials.</p> <p>P/P MM3700, UM 42.0 describe the plan's procedure for authorization approvals for home health and private duty nursing.</p> <p>P/P 17.0 outlines procedures for provider referrals, and indicates that outreach to members is conducted.</p>	
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.		Full	<p>P/P EP 17.0 indicates reports are generated by the EPSDT Department based on claims data to track the number of comprehensive screens reported by age, on time screens, routine evaluation of Hematocrit/Hemoglobin levels, referrals made during the EPSDT screening visit for children up to age 21, immunization history, and automated outreach.</p> <p>The plan provided a screen shot of the PHP EPSDT Call Center application that tracks screens due for each member, last screen conducted and outreach, with results of the outreach call, including disposition and date and time of appointment. Members that opt-out must refuse in writing; refusals are scanned and maintained as per P/P EP 17.0. The plan provided a screen shot of a report of the tracking system of EPSDT screens due; this includes the date of last screen and date screens are due for each member, as well as the PCP. A screenshot of the</p>	



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			<p>electronic referral form from NaviNet was submitted to show how providers complete referrals with diagnosis codes required. A paper referral form was also submitted by the plan.</p> <p>As per onsite staff, required screenings and referrals are documented separately in two different databases. The plan is currently working to link the two databases.</p> <p>The EPSDT Referral Tracking screenshot shows a flow diagram explaining the plan's process to identify an EPSDT referral and to identify and ensure ESPDT members receive all medically necessary services to be compliant with federal EPSDT program guidelines.</p> <p>The EPSDT Program Description also indicates that the Annual EPSDT Evaluation assesses improvements in member and clinical adherence and overall effectiveness of the EPSDT Program.</p> <p>The Provider Orientation Kit implies that referrals are tracked through NaviNet and JIVA tracks online authorizations for home health, acute therapies, and MediPlanner.</p> <p>The Provider Manual states that participation and screening rates are calculated using CMS 416 logic.</p>	



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			<p>P/P EP17.0 indicates the PCP is responsible for coordination of care for referrals and the referral must note the findings based on EPSDT screening. EPSDT-related referrals are collected into an EXP file daily.</p> <p>A Word document and Excel Spreadsheet shows the ratio of case managers to members is 50.3 members per CM. During 2013 there were 90,573 EPSDT eligible members and 4,883 EPSDT providers (18.55 members per provider). During 2013 there were 7,887 EPSDT eligible members with category 1303 (Individuals with Special Health Care Needs.) Of the 7,887 members, there were 151 in Case management.</p>	
<p>H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.</p>		Full	<p>P/P EP 17.0 describes the frequency and type of outreach attempts and cites a case management policy CC 4.05 Identification of Members for Case Management that outlines care coordination procedures for assisting members to obtain needed services; specific pediatric diagnoses and conditions are listed that may require Specialized Case Management defines criteria for medical conditions requiring case management trigger if attempts to reach members fail. Case Management evaluates the circumstances to determine appropriateness of Case Management intervention. P/P CC 5.04, Identification of Members with Special Health Care Needs, describes members with special health care</p>	



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			<p>needs in the context of requiring care coordination, and includes those members who require EPSDT expanded services. The process for communication between case managers and EPSDT when a need for services is identified is described in P/P CC 7.01 Coordination of Care between CM and EPSDT.</p> <p>A Word document and Excel Spreadsheet shows the ratio of case managers to members is 50.3 members per CM. During 2013 there were 90,573 EPSDT eligible members and 4,883 EPSDT providers. During 2013 there were 7,887 EPSDT eligible members with category 1303 (Individuals with Special Health Care Needs.) Of the 7,887 members, there were 151 in Case management.</p> <p>The plan submitted a screen shot of a Care Gap report as evidence of case management. This reports shows which screenings are due for each member.</p> <p>The annual Work Plan reveals outreach telephone calls ranging from about 1,300 to over 12,000 quarterly, and HRA contacts ranging from 112 to 572 quarterly, in addition to reminder postcards, from 200 to nearly 900 quarterly home visits by contracted departments of health, and over 2,000 hospital based postpartum visits.</p>	



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<p>I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.</p>		<p>Substantial</p>	<p>P/P EP 17.0 indicates reports are generated by the EPSDT Department based on claims data to track the number of comprehensive screens reported by age, on time screens, routine evaluation of Hematocrit/Hemoglobin levels, referrals made during the EPSDT screening visit for children up to age 21, immunization history, and automated outreach. Outreach is also described in the 2013 EPSDT Program Description.</p> <p>The plan provided a screen shot of the PHP EPSDT Call Center application that tracks screens due for each member, last screen conducted and outreach, with results of the outreach call, including disposition and date and time of appointment. Members that opt-out must refuse in writing; refusals are scanned and maintained as per P/P EP 17.0. The plan provided a screen shot of a report of the tracking system of EPSDT screens due; this includes the date of last screen and date screens are due for each member, as well as the PCP. A screenshot of the electronic referral form from NaviNet was submitted to show how providers complete referrals with diagnosis codes required. A paper referral form was also submitted by the plan.</p> <p>As per onsite staff, required screenings and referrals are documented separately in two different databases. The plan is currently</p>	<p>Passport Response: Passport agrees and continues to work towards a single database for tracking.</p>



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			<p>working to link the two databases.</p> <p>The EPSDT Referral Tracking screenshot shows a flow diagram illustrating the plan's process to identify an EPSDT referral and to identify and ensure ESPDT members receive all medically necessary services to be compliant with federal EPSDT program guidelines.</p> <p>P/P EP17.0 indicates the PCP is responsible for coordination of care for referrals and the referral must note the findings based on EPSDT screening. EPSDT-related referrals are collected into an EXP file daily.</p> <p>Recommendation for PHP Currently there are two systems for tracking screening and referrals. The plan should continue with efforts to link the screening and referral database to ensure that the needs of each individual member can be easily tracked in one record and receipt of appropriate services ensured.</p>	
<p>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.</p>		<p>Full</p>	<p>10-24 Behavioral Health Training (Behavioral Health Provider Training: Program Overview and Helpful Information) and PHP to Beacon Referral Form reveals the coordination of mental health services through the vendor, Beacon Health Strategies, LLC.</p> <p>The plan provided P/P BH 3.0 Behavioral</p>	



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			<p>Health Liaison Responsibilities, which describes the role of the Behavioral Health Liaison in coordinating the assessment and treatment of behavioral health services for members.</p> <p>The plan provided quarterly presentations from the Joint Operations Committee illustrating coordination between PHP and Beacon and addressing clinical and utilization updates.</p> <p>The plan provided the Provider Manual and an updated version of the Provider Manual Behavioral Health section that is under review by DMS at the time of the onsite; the manual and in particular the revision outline processes for clinical coordination between behavioral health providers and PCPs, including the requirement that behavioral health providers communicate with PCPs if members consent. Coordination is also addressed in Beacon Health Strategies P/P UM 62.21 Member Services and Clinical Referral and Triage Process, and UM 93.11 Collaboration and Referral of Medical and Behavioral Health Cases between Beacon Health Strategies and Partner MCO.</p> <p>The submission of EPSDT data is included in behavioral health provider agreements. Behavioral health services are included in the EPSDT referral tracking database as demonstrated by onsite staff.</p>	



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<p align="center">Early and Periodic Screening, Diagnosis and Treatment (EPSDT) <i>(See Final Page for Suggested Evidence)</i></p>				
<p align="center">State Contract Requirements (Federal Regulation: Not Applicable)</p>	<p align="center">Prior Results & Follow-Up</p>	<p align="center">Review Determination</p>	<p align="center">Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)</p>	<p align="center">Health Plan's and DMS' Responses and Plan of Action</p>
			<p>P/P BH Level of Care Criteria 10.13 describes the vendor's level of care criteria. These criteria include inpatient treatment for EPSDT-identified substance abuse.</p> <p>Screenshots from the Beacon Computer Management System show how the Beacon Representative must complete a section as part of the Utilization Review as to whether the primary care provider had been alerted about the stay or not by the facility when a member is admitted as an inpatient.</p>	
<p>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.</p>		<p align="center">Full</p>	<p>The plan's Desktop Procedure for EPSDT Special Services is intended to ensure compliance with 42 U.S.C. § 1396d(e) and provide any medically necessary health care that falls within the scope of services to a child, even if the service is not available under the State's Medicaid plan to adults. A request for review of services must follow Regulation 907 KAR 11:034. Approval for services is dependent on medical necessity using the criteria outlined in the policy. In accordance with 907 KAR 1:715, school health services including authorized Individual Education Program (IEP) shall be considered to be medically necessary and shall not be subject to further Medicaid prior authorization requirements. Requests for community-based services shall be individually assessed for appropriateness in keeping with the standards of medical</p>	



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			necessity and the best interest of the child.	
K. Participate in any state or federally required chart audit or quality assurance study.		Full	<p>The QI Program Description indicates the plan will assist in data collection for selected components of contractual reporting requirements for accrediting bodies and external review agencies.</p> <p>The plan submits CMS Form 416 quarterly and evaluates results.</p> <p>The plan participated in a review of EPSDT services conducted by the EQRO on behalf of the State by providing requested medical records for review.</p>	
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.		Substantial	<p>EPSDT education is provided through the provider website, NaviNet, the provider manual, the EPSDT Orientation Kit, the New Provider Orientation Packet, and face-to face workshops and onsite visits performed by the Provider Network Account Manager. Details on each of these items as they pertain to relaying information and updates to providers are described in previous items above.</p> <p>The provider newsletter is used to send providers updates to policy changes as per the sample newsletter dated 3/27/13. P/P EP17.0 describes other provider outreach methods including: eNews Alerts, written notice, provider website postings, and provider workshops.</p>	Passport Response: Passport acknowledges the recommendation.



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			<p>The current AAP periodicity recommendations for screening (2014), particularly developmental screening, were discussed with onsite staff, including the need to update documents such as the Provider Manual with current recommendations. As per onsite staff, updates are currently under consideration in committees.</p> <p>Rosters of attendance of providers at training workshops were provided.</p> <p>In regards to separate training concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services, no evidence was submitted. Onsite staff indicated that EPSDT services could be provided at local health departments as well as by PCPs; evidence of general training was provided but training specific for non-physician staff was not provided.</p> <p><u>Recommendation for PHP</u> The plan should ensure that training specific to procedures for non-physicians who may conduct EPSDT services is available.</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		Full	The plan submits CMS Form 416 quarterly and evaluates results. The plan provided these quarterly reports for the review period. The calculation process uses Screen	



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including the current Form CMS-416.			<p>Procedure Codes (accompanied by diagnosis code), Dental Procedure Codes, Preventive Dental Procedure Codes, Dental Treatment Services Procedure Codes, and Blood Lead Procedure Codes, from all screening claims (this includes dental and blood lead tests) for eligible EPSDT members (taken from current membership as of the end of the reporting period by service date).</p> <p>MCO#38 for the month of 12/2013 was submitted as evidence of EPSDT encounter records. This report lists provider types, billing codes and modifiers used, number of members, and dollar amount paid or denied.</p>	
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.		Full	<p>Job descriptions were submitted for Manager of Care Coordination, Rapid Response and EPSDT as well as the Case Management Technician.</p> <p>The Manager is responsible for managing member outreach teams; Case Management Technician, EPSDT, Health Outcomes, and Maternity through their oversight of day-to-day operations of the EPSDT outreach program, and implementation of all aspects of the EPSDT Home Visit Outreach Program, including supervision and training of all external staff in the service area.</p>	
22.1 Required Functions				



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L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.		Full	Arranging for and assisting with scheduling EPSDT services is addressed in P/P EP 17.0. All member materials identify Member Services contacts for assistance with accessing EPSDT services. The tracking databases include evidence of appointments made and disposition of cases with regard to required services.	
37.9 EPSDT Reports				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.		Full	As per MCO Report #38, the plan submits encounter records for EPSDT services including use of EPSDT procedure codes. Encounter data with appropriate codes and EP modifier were provided. As noted above, PHP submits quarterly and annual EPSDT services on Form CMS-416.	



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	16	4	0	0
Total Points	48	8	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.80		

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

Reviewer Decision:

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

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



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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
5.3 Delegations of Authority				



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The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.		Full	PHP utilized 12 subcontractors during the review period. ACS/Xerox (subrogation) initial date of delegation 5/13/13 AmeriHealth HMO (family planning) initial date of delegation 9/19/97 – termination date 11/1/13 AmeriHealth Caritas (TPA) initial date of delegation 9/19/97 Avesis TPA Inc. (Dental) initial date of delegation 10/1/12 Beacon Health Services (Behavioral Health) initial date of delegation 1/1/13 Block Vision (Vision) initial date of delegation 10/1/97 McKesson Health Solutions (24 hour Nurse Line) initial date of delegation 9/1/12	



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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>MedSolutions (radiology) initial date of delegation 10/1/12</p> <p>Optum (credentialing verification) initial date of delegation 7/1/13</p> <p>PerformRx (PBM) initial date of delegation 5/20/04</p> <p>University of Louisville Physicians (provider credentialing for U of L) initial date of delegation 12/1/10 – termination date 9/1/13</p> <p>TC Health (FWA) initial date of delegation 4/15/12</p> <p>This requirement is addressed in the Subcontractor Oversight Policy and Procedure.</p> <p>The requirement is communicated to the subcontractors through their Subcontractor Agreement.</p> <p>PHP provided fully executed agreements for each of the 12 delegated entities.</p>	
<p>B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.</p>		<p>Full</p>	<p>This requirement is addressed in the Delegation Oversight Manual as well as the Subcontractor Oversight Policy and Procedure.</p>	



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			Evidence of pre-delegation audits were provided for all entities contracted with during the review period: ACS/Xerox, Beacon Health Services and Optum.	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.		Full	<p>This requirement is addressed in the Delegation Oversight Manual and the Subcontractor Oversight Policy and Procedure.</p> <p>The requirement is communicated to the subcontractors in the Subcontractor Agreements.</p> <p>PHP monitors each delegated entity at least quarterly and performs an annual formal audit of each delegation.</p> <p>Annual Audit dates and results:</p> <p>ACS/Xerox initial date of delegation 5/13/13 – no annual report needed</p> <p>AmeriHealth HMO termination date 11/1/13</p> <p>AmeriHealth Caritas – annual review completed on 11/20/13; full compliance</p> <p>Avesis TPA Inc. – 12/31/2013; full compliance</p> <p>Beacon Health Services initial date of</p>	



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			delegation 1/1/13 – no annual report needed Block Vision – annual audit 7/29/13; full compliance McKesson Health Solutions – annual audit 11/22/13; full compliance MedSolutions – annual audit 12/19/2013; corrective action plans (CAPs) Optum initial date of delegation 7/1/13 – no annual report needed PerformRx – annual audit 12/23/13; CAPs University of Louisville Physicians termination date 9/1/13 TC Health – annual audit 5/24/13; full compliance	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.		Full	This requirement is addressed in the Delegation Oversight Manual. This requirement is communicated to the subcontractor through the pre-delegation summary report and also through the subcontractor agreement.	



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			This requirement is implemented through the ongoing monitoring of each subcontractor and through the annual audit.	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.		Full	This requirement is addressed in the Delegation Oversight Manual. This requirement is communicated to the subcontractor through the subcontractor Agreement.	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.		Full	This requirement is addressed in the Delegation Oversight Manual.	
7.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.		Full	This requirement is addressed in the subcontractor agreement. PHP provided evidence of a current agreement with each of its delegates whereby each Agreement provided that the subcontractor shall indemnify, defend and hold harmless the Commonwealth, its officers, agents and employees and each and every member from any liability arising in connection with its Contract for the payment of any debt 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		Full	This requirement is addressed in the subcontractor agreement.	



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<p>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.</p>			<p>This requirement is communicated to the subcontractor through the subcontractor agreement.</p>	
7.2 Requirements				
<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</p>		<p>Full</p>	<p>This requirement is addressed in the subcontractor agreement.</p> <p>The Delegation Policy addresses the requirement that all amendments to the subcontractor agreement be in writing and approved by DMS (Section 2.2.3).</p>	



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Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.				
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
C. Specify procedures and criteria for extension, renegotiation, and termination;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
D. Specify that Subcontractors use only Medicaid providers in accordance with this Contract;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	



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F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;		Full	This requirement is addressed in subcontractor agreement and amendment documentation. Onsite, the plan provided an in-depth analysis of the monitoring process that governs the quality of services rendered to members.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;		Full	This requirement is addressed in subcontractor agreement and amendment documentation.	
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,		Full	This requirement is addressed in subcontractor agreement and supporting documentation.	
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and		Full	This requirement is addressed in subcontractor amendment and addendums.	



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Quality Assessment and Performance Improvement: Structure and Operations – Delegated 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
procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,				
(2) all QAPI requirements,		Full	This requirement is addressed in subcontractor agreement.	
(3) all record keeping and reporting requirements,		Full	This requirement is addressed in subcontractor agreement.	
(4) all obligations to maintain the confidentiality of information,		Full	This requirement is addressed in subcontractor agreement.	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,		Full	This requirement is addressed in subcontractor agreement.	
(6) all indemnification and insurance requirements, and		Full	This requirement is addressed in subcontractor agreement.	
(7) all obligations upon termination;		Full	This requirement is addressed in subcontractor agreement.	
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;		Full	This requirement is addressed in subcontractor agreement. The subcontractor's performance is monitored regularly with a comprehensive evaluation occurring annually.	
M. A Subcontractor with NCQA/URAC or other national		Full	This requirement is addressed in	



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accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.			<p>subcontractor agreement.</p> <p>This provision, in the past, was not included in PHP's contract unless the subcontractor had NCQA accreditation. In 2012, this provision was included as a standard provision in PHP's addendum template.</p> <p>The subcontractors are also made aware of this requirement through a quarterly newsletter.</p>	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.		Full	<p>This requirement is addressed in subcontractor agreement as well as in amendment and addendum documentation.</p> <p>CAPs monitoring – A timeline is established for the monitoring of the CAP actions and reported back to Delegation committee to keep track of the efforts of the entity to improve.</p> <p>Participation has been found to be much higher due to this approach. Only one CAP was outstanding at the end of 2013.</p>	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.		Full	<p>This requirement is addressed in subcontractor agreement and amendment documentation.</p> <p>This requirement is communicated to</p>	



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			the subcontractors through the subcontractor agreement. Quarterly delegate newsletters serve to remind the subcontractors of contractual responsibilities.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.		Full	<p>This requirement is addressed in subcontractor agreement and amendment and addendum documentation.</p> <p>This requirement is communicated to the subcontractors through the subcontractor agreement. Quarterly delegate newsletters serve to remind the subcontractors of contractual responsibilities.</p>	
Section 7.2 requirements would be applicable to Subcontractors characterized as Providers/Risk Arrangements including, but not limited to, physicians, hospitals, ancillary providers, IPAs/PHOs, Provider Networks, and Vision Care, Dental and Behavior Health Services; and to those who interact and assist Members including, but not limited to, Radiology Benefit Manager, Disease Management/Case Management, Health Risk Assessments, Pre-Certification Services, PBM, Recoveries, Translation Services and 24-hour Section 7.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.		Full	<p>This requirement is addressed in subcontractor agreement.</p> <p>This requirement is communicated to the subcontractors through the subcontractor agreement. Quarterly delegate newsletters serve to remind the subcontractors of contractual responsibilities.</p>	
7.3 Disclosure of Subcontractors				



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<p>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 \$250,000 or five percent (5%) of the Subcontractor's operating expense.</p>		Full	<p>This requirement is addressed in subcontractor agreement.</p> <p>This requirement is communicated to the subcontractors through the subcontractor agreement. Quarterly delegate newsletters serve to remind the subcontractors of contractual responsibilities.</p>	
7.4 Remedies				
<p>Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.</p>				



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	34	0	0	0
Total Points	102	0	0	0

Overall Compliance Determination:

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

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

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

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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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
17.1 Encounter Data Submission				
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	Document 06_KY Encounter Process_Passport_11272012_PHP addresses this requirement.	
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	Document 06_KY Encounter Process_Passport_11272012_PHP addresses this requirement.	
At a minimum, the Contractor shall be required to electronically provide Encounter Record to the Department, on a weekly schedule.		Full	PHP provided MCO Report# 64, Encounter Data Summary reports demonstrating weekly submissions of encounter records to the Department.	
Encounter Record must follow the format, data elements and method of transmission specified by the Department.		Full	Document 06_KY Encounter Process_Passport_11272012_PHP addresses weekly encounter submissions.	
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	Document 06_KY Encounter Process_Passport_11272012_PHP addresses this requirement.	



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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
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	PHP submits files in standard HIPAA format.	
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	Addressed in MCO Encounter Technical Workgroup meeting minutes of 10/3/13.	
17.2 Technical Workgroup				
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	PHP provided MCO Encounter Technical Workgroup Meeting minutes 10-03-2013 as support of this requirement.	
18 Kentucky Health Information Exchange (KHIE)				
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 patient clinical data.		Not Applicable	The requirement to submit to KHIE was suspended by KDMS in March 2013. Although the requirements were suspended, the MCO should make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE.	



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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
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 should make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE.	
29.1 Claims Payments				
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	Policy Number: PCSU 16.0 addresses this requirement. PHP also provided report DOI Prompt Payment report 2nd qtr 2013 as evidence of tracking and reporting this requirement.	
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 Number: PCSU 16.0 addresses this requirement. PHP also provided report DOI Prompt Payment report 2nd qtr 2013 as evidence of tracking and reporting this requirement.	



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
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	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average	3.0			

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

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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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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22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.		Full	This requirement is found in Policy No. MS 21.0. The written description to members is found in the Member Handbook.	
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.		Full	The policies and procedures for this requirement are found in the Provider Manual and in MS 21.0. At onsite interview, plan stated that these policies and procedures are provided to any out-of-network provider.	
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;		Full	This right is addressed in the Member Handbook and Provider Manual.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;		Full	This right is addressed in the Member Handbook and Provider Manual.	
C. Consent for or refusal of treatment and active participation in decision choices;		Full	This right is addressed in the Member Handbook and Provider Manual.	
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;		Full	This right is addressed in the Member Handbook and Provider Manual.	



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E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;		Full	This right is addressed in the Member Handbook and Provider Manual.	
F. Timely access to care that does not have any communication or physical access barriers;		Full	This right is addressed in the Member Handbook and Provider Manual.	
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;		Full	This right is addressed in the Member Handbook and Provider Manual.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;		Full	This right is addressed in the Member Handbook and Provider Manual.	
I. Timely referral and access to medically indicated specialty care; and		Full	This right is addressed in the Member Handbook and Provider Manual.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.		Full	This right is addressed in the Member Handbook and Provider Manual.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:		Full	Addressed in the Member Handbook and Provider Manual.	
B. Abide by the Contractor's and Department's policies and procedures;		Full	Addressed in the Member Handbook and Provider Manual.	
C. Become informed about service and treatment options;		Full	Addressed in the Member Handbook and Provider Manual.	
D. Actively participate in personal health and care decisions, practice healthy life styles;		Full	Addressed in the Member Handbook and Provider Manual.	
E. Report suspected Fraud and Abuse; and		Full	Addressed in the Member Handbook and	



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			Provider Manual.	
F. Keep appointments or call to cancel.		Full	Addressed in the Member Handbook and Provider Manual.	
22.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.		Full	The Member Handbook procedures and mailing requirements are stated in Policy No. PA 53.0. The policy is compliant with this requirement.	
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.		Full	The Member Handbook is available in English and Spanish according to the documents provided. According to policy PA 13.0 and CLAS 1.06 Plan materials such as the member handbook will be made available to languages 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.		Full	This requirement is addressed in Policy No. PA 53.0.	
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		Full	This requirement is addressed by policy PA 13.0.	



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the authority to review the Contractor's Member Handbook at any time.				
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:		Full	This requirement is addressed in Policy No. PA 13.0.	
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephone numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;		Full	The policy for the network listing is detailed in PA 38.1. The Provider Directory is available in paper and online format.	
B. The procedures for selecting a PCP and scheduling an initial health appointment;		Full	The required information is listed on p. 6 of the Member Handbook.	
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;		Full	The required information is listed on p. 2 of the Member Handbook.	
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;		Full	The covered services, limitations and exclusions are detailed on p. 10-12 of the Member Handbook.	
E. Member rights and responsibilities including reporting suspected fraud and abuse;		Full	The requirement is addressed on p. 27-28 of the Member Handbook.	
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;		Full	Addressed on p. 13 of the Member Handbook.	



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G. Procedures for obtaining transportation for both emergency and non-emergency situations;		Full	Addressed on p. 46 of the Member Handbook.	
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;		Full	These services are listed on p. 22-25 of the Member Handbook.	
I. Procedures for arranging EPSDT for persons under the age of 21 years;		Full	This requirement is listed on p. 24-25 of the Member Handbook.	
J. Procedures for obtaining access to Long Term Care Services;		Full	This requirement is listed on p. 16 of the Member Handbook.	
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;		Full	This is listed on p. 24 of the 2013 Member Handbook.	
L. A list of direct access services that may be accessed without the authorization of a PCP;		Full	This requirement is listed on p. 12 of the Member Handbook.	
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;		Full	This requirement is detailed on p. 6-8 of the Member Handbook.	
N. Information about how to access care before a PCP is assigned or chosen;		Full	This information is provided on p. 7 of the Member Handbook.	
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;		Full	This requirement is found on p. 19 of the Member Handbook.	
P. Procedures for obtaining Covered Services from non-network providers;		Full	This procedure is listed on p. 19 of the Member Handbook.	
Q. Procedures for filing a Grievance or Appeal. This shall		Full	The procedure for filing a Grievance or	



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include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;			Appeal is found on p. 29-30 of the Member Handbook.	
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;		Full	This requirement is listed on p. 32 of the Member Handbook.	
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;		Full	Addressed on p. 26-27 of the Member Handbook.	
T. Information on the availability of health education services;		Full	Addressed on p. 25, 41 and 45 of the Member Handbook.	
U. Information deemed mandatory by the Department; and		Not Applicable	Per plan, State has not identified any additional information; this is done on an ad hoc basis.	
V. The availability of care coordination, case management and disease management provided by the Contractor.		Full	This requirement is addressed on p. 14, 21 and 20 respectively, of the Member Handbook.	
30.3 Second Opinions				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request for a second opinion.		Full	Information on requesting second opinions is listed on p. 19 of the Member Handbook, and in two sections in the Provider Manual.	
22.1 Required Functions				
The Contractor shall have a Member Services function		Full	This requirement is addressed in Member	



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that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Standard Time (EST). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.			Service Call Center document for 2013 and in the Member Handbook.	
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).		Full	This requirement is addressed in the Member Handbook.	
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.		Full	Monthly performance is addressed in the document "MCO Monthly Report for December 2013."	
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		Full	This requirement is addressed in CLAS 1.07 and CLAS 1.09.	



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health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.				
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.		Full	Addressed in PCP Agreement and Member Handbook.	
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;		Full	The policy regarding dissemination of this information is stated in MS 21.0. The rights and responsibilities are also listed in the Member Handbook.	
B. Monitoring the selection and assignment process of PCPs;		Full	This requirement is referenced in MS 6.0 and MS 11.0 as being performed by Member Services staff.	
C. Identifying, investigating, and resolving Member		Full	This requirement is stated in MS 11.0.	



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Grievances about health care services;				
D. Assisting Members with filing formal Appeals regarding plan determinations;		Full	This requirement is stated in MS 11.0.	
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;		Full	This requirement is stated in MS 11.0.	
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;		Full	This requirement is stated in MS 11.0.	
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;		Full	This requirement is stated in MS 11.0.	
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);		Full	This requirement is stated in MS 11.0.	
I. Explaining or answering any questions regarding the Member Handbook;		Full	This requirement is stated in MS 11.0.	
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through		Full	This requirement is stated in MS 11.0.	



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telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;				
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.		Full	This requirement is addressed in MS 11.0 and the Member Handbook.	
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;		Full	This requirement is stated in MS 11.0.	
M. Providing Members with information or referring to support services offered outside the Contractor's		Full	This requirement is stated in MS 11.0.	



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Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;				
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;		Full	This requirement is stated in MS 11.0.	
O. Facilitating access to behavioral health services and pharmaceutical services;		Full	This requirement is stated in MS 11.0.	
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;		Full	This requirement is stated in MS 11.0.	
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;		Full	This requirement is stated in MS 11.0.	
R. Assisting members in obtaining transportation for both		Full	This requirement is stated in MS 11.0.	



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emergency and appropriate non-emergency situations;				
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;		Full	This requirement is stated in MS 11.0.	
T. Facilitating access to Member Health Education Programs;		Full	This requirement is stated in MS 11.0.	
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in Covered Services upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and		Full	This requirement is stated in MS 11.0.	
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.		Full	This requirement is stated in MS 11.0.	
30.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of		Full	This requirement is stated in the Member Handbook, Provider Manual and in the provider contract.	



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the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.				
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.		Full	Addressed in the Provider and Member Handbooks.	
22.9 Choice of Providers				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.		Full	This requirement is stated in the Member Handbook and PCP Directory Listing.	
The Contractor shall have two processes in place for Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.		Full	Member Handbook addresses a process to choose a PCP. Policy MS71.0 – PCP Auto assignment process addresses adult members who have SSI without Medicare.	
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from		Full	This requirement is addressed in MS 6.0.	



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coverage, or when a PCP change is as part of the resolution to an Appeal.				
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.		Full	This requirement is stated in the Member Handbook. Members are given up to thirty (30) days of the approved change to select another PCP.	
A member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.		Full	This requirement is addressed in MS 6.0.	
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.		Full	Addressed in MS 6.0 Primary Care Provider.	
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.		Full	This requirement is stated in the Member Handbook.	
PCPs shall not have the right to request a Member's		Full	This requirement is fully stated in the	



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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.			Provider Manual.	
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.		Full	This requirement is fully stated in the Provider Manual.	
The Contractor shall provide written notice within fifteen (15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the Contractor's network.		Full	This requirement is stated in MS 11.0.	
30.5 Referral for Non-covered Contractor Services				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the contract, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Member for Non-Covered services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit		Full	Addressed in MS 11.0.	



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State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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	3	2	1	0
Number of Elements	85	0	0	0
Total Points	255	0	0	0

Overall Compliance Determination:

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

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

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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Enrollee Rights and Protection: Enrollee Rights Suggested Evidence

Documents

Policies/Procedures for:

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

Member Handbook including any separate inserts or materials

Sample Member newsletters and other informational materials

Sample Provider newsletters and other informational materials

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

Sample of member notifications of voluntary and involuntary PCP termination

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

Reports

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

Annual Member Services Report

Call center metrics

Medical call-in system metrics



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Enrollee Rights and Protection: Member Education and Outreach
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State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
22.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.		Full	This requirement was found in 2013 Outreach Plan and PA 1.13.	
Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.		Full	This requirement is found in 2013 Outreach plan and PA 1.13. During the onsite visit, the plan showed IPRO an Access database printout that details a variety of outreach efforts.	
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.		Full	The annual outreach plan was found in 2013 Outreach Plan document. At onsite interview, plan provided documentation of tracking and evaluation including a member survey.	
22.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population within the Contractor's Region and by implementing and maintaining a customized outreach plan for Homeless		Full	This requirement is found within PA 1.11.	



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State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Persons population, including victims of domestic violence.				
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.		Full	This requirement is found within PA 1.11.	
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.		Full	Outreach efforts intentions to include this population are documented in the Outreach Plan. The definition of a homeless person includes those potentially affected by domestic violence in PA 1.11. The plan shared homeless educational materials at the onsite visit. Transportation assistance is documented in the Member Handbook for all Members.	
22.5 Member Information Materials				
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,		Full	This requirement is found in PA 13.0.	
be published in at least a 14-point font size, and		Full	This requirement is found in PA 13.0.	
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).		Full	This requirement is found in PA 13.0.	
Font size requirements shall not apply to Member Identification Cards.		Full	Addressed in PA 52.0.	
Braille and audiotapes shall be available for the partially blind and blind.		Full	This requirement is found in PA 13.0.	



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Enrollee Rights and Protection: Member Education and Outreach
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State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Provisions to review written materials for the illiterate shall be available.		Full	Member Handbook states members can call Member Services to speak about benefits. Policy MS 11.0 Member Services Department Function addresses "Face to face contact with members".	
Telecommunication devices for the deaf shall be available.		Full	This requirement is found in PA 13.0 and the Member Handbook.	
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.		Full	This requirement is found in PA 13.0.	
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.		Full	This requirement is found in PA 13.0.	
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.		Full	This requirement is found in PA 13.0.	
28.12 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in		Full	This requirement is found in CLAS 1.07.	



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

State Contract Requirements (Federal Regulation 438.206, 438.10)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
<p>policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.</p>				
<p>The Contractor shall communicate such policies to Subcontractors.</p>		Full	<p>This requirement is found in CLAS 1.07 and CLAS 1.09.</p>	



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Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	18	0	0	0
Total Points	54	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average	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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Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

Member and Community Education Outreach Plan

Outreach plan for homeless persons

Member Handbook

Member informational materials

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

Reports

Reports of outreach activities



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Medical Records <i>(See Final Page for Suggested Evidence)</i>				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
38.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.		Full	<p>This requirement is addressed in P/P QM 5.00 Medical Records Standards and Review, which outlines the plan's medical record policy and procedure. P/P QM 5.00 includes Attachment A, which documents the plan's medical record keeping standards, and includes legibility, organization, updates, confidentiality and detailed documentation standards. QM 5.00 includes required signature of provider of service. Consultant notes and hospital records are specifically included in policy and procedure, and prescription files are included in Business Associate Agreements.</p> <p>These requirements are also addressed in the Business Associate Agreement, the BAA for Expansion Contract and Region 3. In addition, the plan provided the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual) that addresses these requirements.</p>	

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The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.		Full	This requirement is addressed in P/P PHP 23 Member Right of Access to Protected Health Information, as well as P/P QM 5.00. This requirement is also reflected in the Business Associate Agreement, the BAA for Expansion Contract and Region 3. In addition, the plan provided the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document. P/P UM Medical Records Storage and UM 30.0 Confidentiality and Privacy Guidelines also address this requirement.	
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.		Substantial	<p>Medical record confidentiality standards are included in P/P QM 5.00, although HIPAA audits are not specifically described. However, information regarding HIPAA privacy and security audits of providers is included in the Provider Manual, with audit elements and procedures outlined in the manual in section 4.5. Onsite staff indicated that provider audits for privacy and security are conducted in initial and onsite audits, and during quality audits and in response to complaints. Section 4.5 of the Provider Manual, which includes medical record confidentiality standards, is cited in provider audit result summary letters.</p> <p>Recommendation for PHP The plan should include audit of confidentiality standards as part of medical record standards in medical record</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation by adding Confidentiality standards to Passport's QM 5.00 – Medical Record and Standards Policy, see page 4.</p> <p align="center">  QM 5.00 - Medical Record Standards and </p>



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			policies/procedures.	
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.		Full	The requirement is addressed in Section 3.4.2 Medical Records of the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document. Access to medical records is addressed in provider and subcontractor agreements. Requirement for transfer of medical records within ten days of receipt of signed request is addressed in the Provider Manual section 3.4.2. This information is also included in the provider orientation kit.	
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.		Full	Medical record audits are addressed in the Provider Manual and Business Associate Agreement. In addition, the plan provided 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual). Procedures for failed audits are outlined in P/P PR 136.0 Failed Medical Record Audit-Process for Follow Up with Provider. Provider records are reviewed every 3 years. Providers are re-reviewed the following year if they do not achieve 80% compliance, and if again fail to achieve 80% or there is a	



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			sentinel event or quality concern, the plan conducts a site visit to discuss audit results. The site visits are conducted by a Provider Network Manager and QI nurse. Unresolved negative trends are referred to the Credentialing Committee.	
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:		Substantial	<p>P/P QM 6.0 Quality and Continuity Coordination of Medical Record Review includes procedures for PCP medical record review related to continuity and coordination of care, such as information sharing between specialists and PCPs, ensuring follow-up care, and outreach following ED use. P/P QM 5.00 describes annual medical record review to address HEDIS clinical measures, Kentucky DMS outcome measures, compliance with Clinical Practice Guidelines and documentation standards including continuity and coordination of care.</p> <p>As per P/P QM 5.00 PCPs are reviewed once every three years. Although not specifically addressed in policy/procedure, onsite staff indicated that dental providers are assessed based on trending and specialists during review of quality concerns and also during HEDIS reviews. The plan provided a summary of 2013 audit results, and evidence of review of 64 practice sites, including family practice, internal medicine, general medicine, OB GYN and pediatric practices.</p>	<p>Passport Response: Passport Health Plan is in the process of acting upon IPRO's recommendation by revising the Medical Record Review process. Changes to the audit process will include methodology for the assessment of dental and ancillary providers. Policies and procedures related to Medical Record Review will be updated accordingly.</p>



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			<p>Recommendation for PHP The plan should include methodology for assessment of dental and high volume specialty providers in policies and procedures.</p>	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;		Full	As per QM 5.00, the purpose of medical record review includes evaluation of provider compliance with clinical practice guidelines. PCP audit results were provided in an audit summary document.	
B. Allow for the tracking and trending of individual and plan wide provider performance over time;		Full	As per P/P QM 5.00, results of audits are logged and maintained in a database; practitioners not meeting the 80% compliance threshold are notified of results and actions for improvement and re-reviewed. As per P/P PR 136.0 unresolved trends are referred to Credentialing Committee. Results of medical record audits are included in the QI Program Evaluation.	
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and		Full	This requirement is addressed in QM 5.00, P/P 136.0 and the Provider Manual. As per QM 5.00, practitioner medical records are reviewed by a clinical quality review nurse in cases of sentinel events or when complaints regarding quality of care are identified. As per P/P 136.0, quality of care concerns in the case of failed medical record audit result in a site visit.	
D. Include mechanism for detecting		Full	This is addressed in P/P QM 5.00. Medical	



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instances of over-utilization, under-utilization, and miss utilization.			records are reviewed for treatment plans consistent with diagnosis, and emergency care and follow-up.	
27.6 Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.		Full	This requirement is addressed in P/P QM 5.00. This requirement is also addressed in the Provider Manual provided by the plan, specifically; section 4.5 Medical-Record-Keeping & Continuity & Coordination of Care Standards.	
The Member's Medical Record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained		Full	Access to medical records is addressed in QM 5.00 and P/P PHP 23. This is also addressed in the contract agreements with the plan. The following were provided: Ancillary Provider Contract Agreement, Behavioral Health Provider Agreement, Critical Access Hospital Template, Hospital Agreement, Specialist Contract State Wide,	



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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).			FQHC State Wide Contract and the agreement with the Department for Public Health (DPH). The right to obtain a copy of the medical record is included in Member Handbook. The requirement to maintain medical records for a minimum of five years is included in provider contract agreements.	
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:		Full	This requirement is addressed in P/P QM 5.00. This requirement is also addressed in the Provider Manual, specifically, the 4.0 Office Standards and 4.5 Medical-Record-Keepering & Continuity & Coordination of Care Standards sections. Also addressed in QM 5.0.	
A. Member/patient identification information, on each page;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual.	
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;		Full	This requirement is addressed in P/P QM 5.00. This requirement is also addressed in the Provider Manual.	

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C. Date of data entry and date of encounter;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual.	
D. Provider identification by name;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is addressed in the Provider Manual.	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual provided by the plan. Specifically, the 4.5 Medical-Record-Keeping & Continuity & Coordination of Care Standards.	
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);		Substantial	<p>This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual.</p> <p>P/P QM 5.00 Appendix A indicates that past medical history should be documented for members seen three or more times. The importance of past medical history regardless of number of times seen, since it can impact diagnoses and therapy choice, was discussed onsite.</p> <p><u>Recommendation for PHP</u> The plan should ensure that past medical history is included in all medical records regardless of number of times seen.</p>	<p>Passport Response: Passport Health Plan has acted upon IPRO's recommendation. The statement of past medical history three or more times has been removed from the appendix document.</p> <p align="center">  QM 5.00 - Medical Record Standards and </p>
G. Identification of current problems;		Full	This requirement is addressed in P/P QM 5.00, Appendix A, which includes a problem	



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			list. This requirement is also addressed in the Provider Manual.	
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also in the Provider Manual.	
I. Documentation of immunizations pursuant to 902 KAR 2:060;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual.	
J. Identification and history of nicotine, alcohol use or substance abuse;		Full	This requirement is addressed in P/P QM 5.00, Appendix A. This requirement is also addressed in the Provider Manual. Documents specify age 12 years and older for screening; onsite staff indicated that discussion was underway to revise age for screening to a younger age.	
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;		Full	This requirement is addressed in P/P QM 5.00, Appendix A.	
L. Follow-up visits provided secondary to reports of emergency room care;		Full	This requirement is addressed in P/P QM 5.00, Appendix A.	
M. Hospital discharge summaries;		Full	This requirement is addressed in P/P QM 5.00, Appendix A.	



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N. Advanced Medical Directives, for adults;		Full	This requirement is addressed in P/P CC 29.0 Advanced Medical Directives, and also in P/P QM 5.00. This information is communicated to providers in the Provider Orientation Kit.	
O. All written denials of service and the reason for the denial; and		Full	This requirement is addressed in P/P QM 5.00 Appendix A.	
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.		Full	This requirement is addressed in P/P QM 5.00 Appendix A.	
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;		Full	This requirement is addressed in P/P QM 5.00 Appendix A.	
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and		Full	This requirement is addressed in P/P QM 5.00 Appendix A.	
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and		Full	This requirement is addressed in P/P QM 5.00 Appendix A.	



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2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.				
27.7 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.		Full	This requirement is addressed in P/P CC 29.0 Advanced Medical Directives, which references appropriate laws. This requirement is also addressed in the Provider Orientation Kit, specifically, the Member Rights and Responsibility section, the Advanced Medical Directive Policies for Members and Providers policy and the PR 120.0 - Advance Directives Training for Providers policy.	
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.		Full	This information is included in the Member Handbook. This information is also addressed in the Provider Orientation Kit, specifically, the Member Rights and Responsibility section, the Advanced Medical Directive Policies for Members and Providers policy and the PR 120.0 - Advance Directives Training for Providers policy.	
PCPs have the responsibility to discuss		Full	This requirement is addressed in the	



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Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.			Provider Orientation Kit, specifically, the Member Rights and Responsibility section, the Advanced Medical Directive Policies for Members and Providers policy and the PR 120.0 - Advance Directives Training for Providers policy.	
38.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.		Full	The plan provided confidentiality policies onsite that address this requirement, including P/P PHP 23 and UM 30.0. Confidentiality and Privacy. In addition, this information is addressed in the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual).	
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		Minimal	Maintenance of the confidentiality of member information is addressed P/P PHP 23 and UM 30.0, and the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual). Policies and procedures for minors as per contract requirement were not evident in the policies and procedures or Provider Manual provided by the plan. Recommendation for PHP The plan should address provisions for assuring confidentiality of services for	Passport Response: Passport Health Plan respectfully disagrees with this finding. The supporting documentation was provided prior to the onsite. For your convenience, please find the previously submitted Policy CO 12, Personal Representative and Identity Verification of Individuals Requesting PHI that was provided prior to our on-site audit under the QAPI – Structure and Operations – Delegated Services. See page 4, Section 2.

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



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				<p>(See Contract citation below).</p> <p>PHP should consider adopting a P/P for these specific issues and referencing it in CO 12.</p> <p><i>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.</i></p>
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.		Full	<p>P/P UM 30.0 and PHP 23 address required reading and signing of PHP's Confidentiality Agreement for all staff and committee members.</p> <p>BAA confidentiality agreements were provided by the plan. The plan provided the Avesis - Consulting Services Agreement, which includes confidentiality and HIPAA sections.</p>	
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the		Substantial	Access to protected health information consistent with state and federal regulation is addressed in P/P UM 30.0 and PHP 23, as	<p>Passport Response: Passport agrees with the recommendation and has updated UM 30.00. The 2015 Provider</p>

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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.			<p>well as the 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual). This information is included in PHP's Notice of Privacy Practices document for members that are on the plan's member website. The plan does not explicitly address relevant agencies as listed in the contract requirement in submitted policies and procedures.</p> <p><u>Recommendation for PHP</u> The plan should reference persons or agencies which require information to perform duties related to administration of the Department in policies and procedures.</p>	<p>Manual will be updated.</p> <p align="center">  UM 30 0 Confidentiality and Pr </p>
40.12 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the subcontractor be required to abide by the same statutes and regulations regarding		Full	This requirement is addressed in P/P IT 31.00 HIPAA and HITECH Security Compliance Policy. In addition, the plan provided 2013 Provider Manual Confidentiality and Access to Medical Records Standards document (which are sections of the Provider Manual) and the Avesis - Consulting Services Agreement (which includes a HIPAA and confidentiality section).	



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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	3	2	1	0
Number of Elements	35	4	1	0
Total Points	105	8	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	3.0	2.0 – 2.99	1.0 – 1.99	0 – 0.99
Points Average		2.85		

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’ 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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33.3 General Behavioral Health Requirements				
The Department requires the Contractor's provision of mental health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.		Full	Addressed by Enrollee Rights document.	
33.4 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.		Full	Addressed by Availability and Accessibility of Clinical Services, BH LOC 10.3 document.	
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV.		Full	Addressed by BH LOC 10.3 document.	
Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.		Full	Addressed by BH LOC 10.3 document.	
33.5 Behavioral Health Provider Network				
The Contractor must emphasize utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to		Full	Addressed by BH LOC 10.3 document, Sample BH Facility Agreement and Sample BH Provider Agreement.	



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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.		Full	Addressed by Provider Manual.	
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.		Full	Addressed by Availability and Accessibility of Clinical Services document, and Provider Manual.	
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.		Full	Addressed by 2013 QI Work Plan, Sample CMHC Agreement and BH Standard Compliance documents. At onsite interview, Plan explained that all providers were in network for Region 3 prior to 1/1/13. When outside Region 3, single care agreements were secured with CMHC to meet member needs.	
Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.		Full	Addressed by Availability and Accessibility of Clinical Services document, and Provider Manual.	
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.		Full	Addressed by Availability and Accessibility of Clinical Services document.	
To the extent that non-psychiatrists and other providers		Full	Addressed in FQHC State Wide Contract.	



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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.		Full	Addressed by QM 24.19 Availability and Accessibility of Clinical Services policy: At least once per year, Beacon assesses geographic and numeric availability of contractual BH practitioners to ensure network meets needs of members. Per Plan at onsite, no CMHC in Region 3 declined participation. Single case agreements were secured with CMHCs outside Region 3 to meet members' needs.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.		Full	Addressed in Educating Members About How to Obtain BH Services document.	
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.		Full	Addressed in Provider Manual.	
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a		Full	Addressed by BH Services Hotline and Availability and Accessibility of Clinical Services document QM 24.19.	



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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.		Full	Addressed by BH Services Hotline and Availability and Accessibility of Clinical Services document QM 24.19.	
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.		Full	Addressed by BH Services Hotline document UM 289.02, p. 1 addresses Emergency Care and 24 hour access to utilization review staff.	
It is not acceptable for an intake line to be answered by an answering machine.		Full	BH Services Hotline document indicates a staffed hotline is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. QM 24.19, p. 12 states "staffed by trained personnel"; UM 62.27, p. 5 states "calls received via Beacon's dedicated toll free telephone lines are answered live by a Member Services Representative"; clinical emergencies are referred directly to Beacon Clinician per Item #5. UM 1.21 addresses emergency situations. Beacon's automated voice prompt system does use an auto-attendant to answer calls and refer members to live person, but an answering machine is not used per Plan staff during onsite interview.	
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum		Substantial	See sub-components below.	



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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;		Full	Addressed in DMS Report 11 and UM 62.27.	
B. No incoming calls receive a busy signal;		Substantial	Addressed in DMS Report 11 and UM 62.27: "99% of calls received by Beacon will not receive a busy signal. Plan confirmed 99% but not 100%. <u>Recommendation for PHP</u> Policy should be revised to address this requirement at 100%.	<u>Passport Response:</u> Passport acknowledges the recommendation.
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;		Substantial	At least eighty percent (80%) of calls were answered within thirty (30) seconds for all months of 2013 except July (69.24%) and August (75.26%) per Evidence Compliance Hotline Requirements document. In November 2013, over ninety-four percent (94.64%) of calls were answered within thirty (30) seconds. <u>Recommendation for PHP</u> The plan should ensure that at least 80% of calls are answered within 30 seconds.	<u>Passport Response:</u> Passport agrees with the recommendation.
D. The call abandonment rate is seven percent (7%) or less;		Substantial	Call abandonment rate was seven percent (7%) or less for all months of 2013 except July (9.57%). In March 2013, call abandonment rate was zero percent (0%).	<u>Passport Response:</u> Passport agrees with the recommendation.



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			<p>Recommendation for PHP The plans should ensure that the abandonment rate is 7% or less.</p>	
E. The average hold time is two (2) minutes or less; and		Full	Addressed by DMS Report 11 and UM 62.27. DMS Report does report highest maximum delay, which the Plan explained onsite is the same as hold time.	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.		Substantial	<p>UM 62.27, p. 5 states "calls received via Beacon's dedicated toll free telephone lines are answered live by a Member Services Representative"; clinical emergencies are referred directly to Beacon Clinician per Item #5. UM 1.21 addresses emergency situations. Beacon's automated voice prompt system does use an auto-attendant to answer calls and refer members to live person for emergencies, and also instructs member to call 911 for emergencies.</p> <p>The ability to "patch to 911 emergency services" was not noted in documentation or during interview.</p> <p>Recommendation for PHP Patch capabilities for 911 emergency services should be addressed by the behavioral health vendor.</p>	<p>Passport Response: Passport agrees with the recommendation.</p>



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The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.		Full	Addressed in BH Services Hotline document.	
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.		Substantial	DMS Report 11 tracks duration, but policy does not address the requirement to not impose maximum call duration limits. During the onsite interview, the Plan stated that calls are of sufficient length to meet the member's needs. <u>Recommendation for PHP</u> Policy should be revised to include requirement to not impose maximum call duration limits.	<u>Passport Response:</u> Passport agrees with the recommendation.
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.		Substantial	Linguistic access is documented in Member Handbook, but Hotline Cultural Competency requirements were not documented in policy. At onsite interview, Plan explained that cultural competency is a part of yearly training program. <u>Recommendation for PHP</u> Incorporate cultural competency requirements in relevant hotline policies.	<u>Passport Response:</u> Passport acknowledges the recommendation.
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about		Non-Compliance	Not addressed in documents provided either pre-onsite or onsite.	<u>Passport Response:</u> Passport Health Plan respectfully disagrees with the finding. The supporting documentation was provided prior to our onsite. For your



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all such Service Areas, including the Behavioral Health Provider Network in each Service Area.				<p>convenience, please find the previously submitted Behavioral Health section of the Provider Manual, page 3, 19.2 and UM 62.27 – member Services and Clinical Referral and Triage Process.</p> <p align="center">  Provider Manual - Behavioral Health Cha </p> <p align="center">  UM 62.27 - Member Services and Clinical F </p> <p>This information is also covered in our Member Handbook that was supplied for a different portion of the audit. See pages 2, 26 and 27.</p>



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				 <p align="center">Member Handbook - BH.pdf</p> <p><u>Final Review Determination:</u> No change in compliance level.</p> <p>The documents provided do not address the requirement. The Contract indicates that the BHS Hotline may serve multiple Contractor Programs. If the Hotline serves multiple programs, the Hotline staff must be knowledgeable about all Contractor Programs. The BHS Hotline may serve multiple Service Areas. If the Hotline serves multiple Service Areas, the Hotline staff must be knowledgeable about the BH Provider Network in each Service Area.</p> <p>The documents provided address the existence of a BHS Hotline and no need for referral/prior authorization for BHS in an emergency situation only.</p> <p>Evidence of compliance with this requirement would include information</p>



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				regarding whether the Hotline serves multiple MCO Programs/product lines and/or multiple MCO Service Areas or if there are dedicated staffs for each. Additionally, if multiple Programs/Service Areas are served by a single Hotline, evidence that the Hotline staff are knowledgeable about the various Programs, Provider Networks, and Service Areas, in particular, those related to Kentucky Medicaid.
The Contractor shall conduct on-going quality assurance to ensure these standards are met.		Full	Addressed in BH Services Hotline and Evidence Compliance Hotline Requirements documents.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.		Full	Addressed in BH Services Hotline and Evidence Compliance Hotline Requirements documents.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and		Full	Addressed in Sample PCP Contract (page 9).	

Comment [SP1]: Plural?



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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 for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.		Full	Addressed in PCP and Specialist Workshop document.	
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 by Clinical Coordination between BH & PCP document. <u>BH/PH File Review</u> Evidence of Care Coordination could not be assessed using the BH sample provided because 4 of the 10 files provided were for members for whom ICM services were not indicated because such services would have been duplicative of BH services the member was already receiving and the remaining 6 files were for members who did not agree to ICM. During onsite interview plan described several cases of BH-PH care coordination, e.g., for member discharged from psychiatric inpatient care: coordinate with prescribing provider to ensure PH + BH providers are aware of/communicating BH	



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			<p>medication adherence and appropriateness, with long term goals of vocational training and short term goal of maintaining member in the community. CMs embedded in PCP office and in CMHCs. Based upon these cases provided, it appears that the Plan does have a process in place to coordinate BH-PH services.</p> <p>In addition, per file review of a sample selected for assessment of care coordination, 9 files required and received BH-PH care coordination, and per file review of a sample selected for assessment of complex case management, 9 files required and received BH-PH care coordination.</p>	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.		Full	Addressed by Clinical Coordination between BH & PCP document.	
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's		Full	Addressed by Clinical Coordination between BH & PCP document.	



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or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.				
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow- up and/or continuing treatment prior to discharge.		Full	Addressed by Coordination Care Policy.	
The outpatient treatment must occur within fourteen (14) days from the date of discharge.		Full	Addressed by Coordination Care Policy (page 3).	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.		Full	Addressed in Provider Manual 16.2.	
33.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.		Full	Addressed in Beacon Health Strategies LOC criteria, p. 2.	



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The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.		Full	Addressed in LOC Criteria, p. 9.	
33.10 Community Mental Health Center (CMHC)				
The Contractor shall coordinate with the Community Mental Health Center (CMHC) or other qualified special health care providers, other providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric hospital.		Full	Addressed by Provider Manual, BH LOC 10.13 documents.	
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.		Full	Addressed by KY Discharge State Facility Policy.	
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.		Full	Addressed by KY Discharge State Facility Policy.	
The Contractor shall ensure the Behavioral Health Service		Substantial	Partially addressed by KY Discharge	<u>Passport Response:</u>



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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.			<p>State Facility Policy, CC 4.05 Identification of Members for Case Management, and BH Standard Compliance 4th Quarter 2013 (slide 12); there is no mention of co-occurring developmental disabilities in the documents in relation to ICM eligibility. CM KY 30 addresses general requirement but is not specific to members with co-occurring developmental disabilities.</p> <p>At onsite interview, plan explained that this subpopulation is covered under the general umbrella of members discharged from a psychiatric facility. ICM Program Description, p. 10, addresses "children and adolescents with serious emotional and /or behavioral disorders, but not members with co-occurring developmental disabilities.</p> <p><u>Recommendation for PHP</u> Modify policy and program description to explicitly mention members with co-occurring developmental disabilities.</p>	Passport acknowledges the recommendation.
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports		Full	Addressed by KY Discharge State Facility Policy.	



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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.		Full	Addressed by KY Discharge State Facility Policy.	
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.		Full	Addressed in Provider Manual 16.8, p. 208.	
33.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);		Full	Addressed by Availability and Accessibility of Clinical Services, Provider Manual and BH LOC 10.13 documents.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;		Full	Addressed in Provider Manual 16.6.	
C. Identify a method to evaluate the continuity and		Full	Addressed by Clinical Coordination	



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coordination of care, including member-approved communications between behavioral health care providers and primary care providers;			between BH & PCP and Coordination Care Policy documents.	
D. Protect the confidentiality of Member information and records; and		Full	Addressed by UM 30, Confidentiality and Privacy.	
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.		Full	Addressed by 2013 QI Work Plan.	
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				



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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	3	2	1	0
Number of Elements	44	8	0	1
Total Points	132	16	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		2.79		

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’ 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



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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
31.1 Pharmacy Requirements				
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;		Full	The following documents satisfy this requirement: DRUM-2-05 Concurrent Drug Utilization Review.pdf and PRPR00021_Perform_Rx_Provider_Manual (3).pdf.	
B. Retrospective utilization review services;		Full	DRUM-2-06 Retrospective Drug Utilization Review Program.pdf satisfies this requirement.	
C. Formulary and non-formulary services, including prior authorization services;		Full	The following policies and procedures and MCO reports address this requirement: PH 3.01 Prior Authorization of Pharmaceuticals.pdf; PH 8.01 Communicate Pharmacy Procedures & changes.pdf; Prior Auth Drug List.pdf, MCO reports 39 and 59.	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere; and		Full	CSCD-1-05 Customer Care Center Services 7 24 14.pdf satisfies this requirement.	
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors.		Full	The following documents were provided: Data Interfaces with Commonwealth_Pharmacy.pdf; PBM Agreement Article 4.9 & 4.10.pdf; PBM	



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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
			Agreement Article 6 _ claims payment.pdf; HP - Telecommunications Agreement 01DEC2013.pdf; and PRPR00021_Perform_Rx_Provider_Manual (3).pdf.	
31.2 Formulary and Non-Formulary Services				
The Contractor shall maintain a preferred drug list and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.		Full	The following documents and policies and procedures satisfy this requirement: 11-18-pharmacy news issue; 18.2.9.1 Drug Pricing PHP Provider Manual.pdf (infusion therapy only); 2013 Preferred Drug List.pdf (has explanation of PA, ST, QL); PH 2.10 Preferred Drug List.pdf; PH 8.01 Communicate Pharmacy Procedures & changes.pdf, and PRPR00021_Perform_Rx_Provider_Manual (3).pdf.	
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The committee shall meet periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary.		Full	The following documents and policies and procedures satisfy this requirement: 05-30-agenda-pandt-meeting-june-2013[1]; PH 2.02 Standards for Drug Review by Pharmacy and Therapeutics Comm.pdf; PH 2.03 Review of New Drugs for the Drug List.pdf; P&T Committee Minutes; PH 1.01 Pharmacy and Therapeutics Comm.pdf. PH 1.01 Pharmacy and Therapeutics	



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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>Comm.pdf includes a consumer advocate as committee constituent and describes Partnership Council as a venue for consumer voice. P&T meeting minutes do not contain consumer constituent contributions. According to the definition provided within PH 1.01, The Partnership Council meets separately to review P&T and other QI initiatives.</p> <p>Recommendation for PHP The plan could provide, if it so chooses, evidence of Partnership Council contributions to pharmacy benefit policies & procedures, QI initiatives, etc. as this is a potential best practice in patient and member engagement.</p>	
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.		Full	This requirement is satisfied by the following documents and policies and procedures: PH 2.10 Preferred Drug List.pdf; PH 8.01 Communicate Pharmacy Procedures & changes.pdf; 11-18-pharmacy news issue.	
31.3 Pharmacy Claims Administration				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. The Contractor shall		Full	The following documents satisfy this requirement: 2013 PHP Pharmacy Program Description.pdf (description of agreement between PHP and PBM); 4th PBM Amendment.pdf (amendment to	



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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
be responsible for processing components required for paper Claims.			agreement); PerformRx Fifth Amendment 1-24-14 (2).pdf; Data Interfaces with Commonwealth_Pharmacy.pdf; PBM Agreement Article 4.9 & 4.10.pdf; PBM Agreement Article 6 _ claims payment.pdf; Provider ENews-NDC req for Drug Codes.pdf; and PRPR00021_Perform_Rx_Provider_Manual (3).pdf.	
The Contractor maintains, through an online system, appropriate accounts receivable (A/R) records for the Commonwealth to systematically track adjustments, recoupments, manual payments and other required identifying A/R and Claim information.		Full	The following documents satisfy this requirement: 2013 PHP Pharmacy Program Description.pdf (description of agreement between PHP and PBM); 4th PBM Amendment.pdf; PerformRx Fifth Amendment 1-24-14 (2).pdf; Data Interfaces with Commonwealth_Pharmacy.pdf; PBM Agreement Article 4.9 & 4.10.pdf; PBM Agreement Article 6 _ claims payment.pdf and PRPR00021_Perform_Rx_Provider_Manual (3).pdf.	
The Contractor shall interface with the Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.		Full	The following documents satisfy this requirement: Data Interfaces with Commonwealth_Pharmacy.pdf; PBM Agreement Article 4.9 & 4.10.pdf; PBM Agreement Article 6 _ claims payment.pdf; HP -- Telecommunications Agreement 01DEC2013.pdf and PRPR00021_Perform_Rx_Provider_Manual	



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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
			(3).pdf.	
31.4 Pharmacy Rebate Administration				
The Patient and Affordable Care Act (PPACA) signed into law in March 2010 require states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information including J-code conversions consistent with CMS requirements. The Department will provide this Claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacture. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.		Full	The following documents satisfy this requirement: Payment_Allocation_Fed_Supp.pdf and Dispute_Resolution_Fed_Supp.pdf.	
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.		Full	The following reports and policies and procedures satisfy this requirement: Controlled_Drug_Utilization_-_Pharmacy_4Q2013.pdf; CP 40.00 lock-in.pdf; PHP DMS MCO Reports #40A_Monthly 2013-09-10.pdf; PHP DMS MCO Reports #40B_Monthly 2013-09-10.pdf; PHP DMS MCO Reports #41_Monthly 2013-09-10.pdf; 2Q13 ACE_ARB Care Gap Report.pdf, MCO reports 39 and 59.	



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Pharmacy Benefits

Scoring Grid:

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

Overall Compliance Determination:

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

Documents

Policies/procedures for:

- Pharmacy benefit requirements
- Structure of pharmacy program
- Pharmacy claims administration
- Pharmacy rebate administration
- Prospective and retrospective drug utilization review
- Pharmacy restriction program

Preferred Drug List

Listing of drugs requiring prior authorization

Pharmacy & Therapeutics Committee description, membership, meeting agendas and minutes

Process for informing members and pharmacy providers of preferred drug list and related information

Process for evaluating the impact of the pharmacy program on members

Prior authorization process

Reports

Retrospective Drug UR reports