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

Final Report 9.11.13

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.		Substantial	The Quality Assessment and Performance Improvement (QAPI) Program Description 2011-2012 outlines the plan's structure for a systematic approach to monitoring, analyzing, evaluating and improving care delivered to its members. The Program is described as addressing preventive care, acute and chronic care, behavioral health, utilization, continuity and coordination, safety and administrative and network services. The plan described during the onsite meeting and provided evidence for evaluation and improvement activities, with preliminary monitoring of standard indicators. Some activities, such as meetings of the Quality Improvement Committee, did not appear to be consistent throughout 2012 as reflected in submitted documents. For 2012, minutes were provided for February 2012, July 2012, and December 2012 for the QI Committee/QI-UM Committee. The QIC charter indicates that the committee will meet no less than quarterly. No minutes were found for 2Q 2012. February minutes note a meeting	**MCO Response:** KSHP agrees that QI activities are ongoing and that committee meetings occur per policy each quarter. However, 2012 was the start-up year for the Plan. As the startup year, some committees did not meet on their established basis due to other Plan activities. Since 3rd quarter 2012, this committee has met quarterly as per the QAPI Program Description. **IPRO Comments:** No change in review determination.

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			planned in May 2012 but no minutes were found. **Recommendation for KY Spirit** The MCO should ensure that QI activities are ongoing and consistent and that committee meetings occur per policy.	
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 QAPI Program Description documents that the plan monitors preventive, acute, chronic and behavioral health care; continuity and coordination; delegated services; department performance and services; cultural competency; member enrollment/ disenrollment; member and provider complaints , grievances and satisfaction; safety; Primary Care Provider (PCP) changes; pharmacy ; access; credentialing; and utilization. The plan provided policies related to Quality of Care Monitoring and Practitioner Investigations, as well as a QI Work Plan that documents ongoing or planned activities to evaluate delegated services, compliance with medical record standards and clinical guidelines, quality of care concern trends, HEDIS indicators, member complaints and grievances, credentialing indicators, utilization including pharmacy, and access	

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			and availability of providers. The QI Work Plan indicates that the plan is establishing metrics for monitoring continuity and coordination of care and effectiveness of case management and disease management programs. There is evidence of monitoring of EPSDT screens in the first quarterly report.	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.		Full	The QAPI Program Description outlines the plan's quality improvement structure, including staff, committee structure and resources, and processes for evaluation and improvement of quality. Further definition is given to processes in specific policies and procedures, and the QI Work Plan.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.		Full	The plan described during the onsite review and in submitted documents some initial evaluation findings that led to QI projects. As per onsite staff, focus areas were identified by reviewing population information, including Emergency Department (ED) utilization, health care screenings, behavioral health screening and diabetes care. Performance Improvement Project (PIP) topics that were submitted address cervical cancer	

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			screening and behavioral health screening for pregnant women. Onsite staff described efforts to outreach to members with ED visits using daily encounter logs and targeting high utilizers as well as relevant daily encounters. The plan has begun monitoring and conducting outreach for members with diabetes gaps in care. The plan has also implemented care gaps reports for other areas such as immunizations and dental visits, with a script noting gaps in care appearing on customer service screens. The plan has been monitoring preterm birth as noted in the first quarterly report #24, and as per onsite staff the plan has begun work on promoting use of 17 hydroxyprogesterone to reduce preterm rates. The first quarterly report #24 also includes EPSDT screening and participation rates, and documents plan outreach effort initiated to improve them. Quarterly reports note timely Health Risk Assessments (HRAs) to be low for pregnant (21%) and non-pregnant (10.6%) members. Activities to address HRAs were not documented or discussed. The QI Program Description indicates that the QAPI Program	

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			Evaluation findings are used to develop the annual QAPI Program Description; although this evaluation was conducted for the last two months of 2011 as noted in the QI Work Plan and QIC minutes, results and their linkage to QI projects were not provided or discussed. The QAPI Plan is evaluated by the QI/UMC at least twice annually. The plan has not yet undergone an EQR annual evaluation or accreditation process. The plan is reporting HEDIS, CAHPS, and results of the Provider Satisfaction Survey for the first time in 2012/2013 for CY 2012. The 2012 QI Evaluation is not yet completed.	
The QAPI program shall be developed in collaboration with input from Members.		Substantial	The Program Description notes that the purpose of the QMAC is to solicit member input into the Quality Improvement Program. Information regarding the QI program goals, processes and outcomes are provided to members via newsletter and website, as well as the QMAC. Minutes were provided for QMAC meetings July 2012 (teleconference) and November 2012 (in person). Members	**MCO Response:** KSHP agrees that the MAC should conduct activities per the committee charter. However, 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the Plan and presented QI Plan programs, such as Member Connections and Connections Plus Program for review by the MAC. Members were also provided information on Member Services and how they can assist the members. During the second meeting access to care was discussed as it related to physicians who were no longer accepting KSHP. The above activities are noted in the minutes for the meetings and were submitted to the IPRO prior to the

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			provided feedback regarding their experiences with the plan, but no review of QI activities or documents was noted. **Recommendation for KY Spirit** The MCO should ensure that the QMAC conducts activities per the committee charter.	review. As these meetings evidenced review of KSHP Programs and provided for discussion of access to care, the Plan requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.		Full	The committee met twice during CY 2012. This is compliant with the committee description.	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.		NA	The QI Work Plan includes a target of 2-4 years post "go live" date for NCQA accreditation. The plan has not yet attained accreditation, but has undertaken activities in preparation for the accreditation process.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.		NA	NA - the plan has not yet undergone the accreditation process.	

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Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.		Full	The QI Work Plan notes that the QAPI Program Description is to be submitted to the State by July 31 annually.	
As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.		Full	As per the QAPI Program Description, the plan has delegated management of the behavioral health program to Cenpatico Behavioral Health (CBH), including the behavioral health quality improvement program. The Program Description notes that there will be an ongoing systematic process for monitoring and evaluating behavioral health including clinical change, such as functional improvement and symptom reduction. These metrics were not provided for review, and do not appear to have been reported. However, the plan's onsite staff report monitoring prescribing practices for behavioral health, and tools were developed and feedback on practice patterns provided to the Community Health Center with which the providers are affiliated as per quarterly reports in second quarter 2012. It is noted in the Program Description that provider compliance with clinical practice guidelines is delegated to CBH; review of compliance does not appear in documents that were provided. CBH administered an	

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			adult and child satisfaction survey in 2012. Results were submitted to the Department in quarterly reports. First quarterly report #16 documents adverse event monitoring and investigation by CBH. The plan described onsite and in quarterly reports several behavioral health initiatives and programs to improve care, including integrating of behavioral health with the plan's Medical Management, working with DCBS for transition planning for youth in Residential Treatment Facilities (PRTF) placement, and providing intensive case management for members with frequent hospitalizations. Onsite staff noted that population specific reports are generated for children in foster care, Seriously Mentally Ill (SMI), and members with behavioral health and chronic medical conditions, such as COPD and diabetes. Cenpatico (CBH) submitted documentation of the QI Program for BH, including the NCQA Accreditation certificate, QI Program Description, QI Work Plan, QIC and UM Committee minutes, P/P for Member Complaints, Provider Complaints, Potential Quality of	

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			Care issues, Evaluation of Access, Clinical Practice Guidelines. As well as reports of: Member Grievances, Analysis of Appeals, Utilization, UM Authorizations, Child Member Survey, Provider Satisfaction Survey, HEDIS Follow-up after Hospitalization for Mental Illness, Evaluation of Practitioner Compliance with Clinical Practice Guidelines, and Quarterly reports to DMS.	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.		Full	The QAPI Program Description indicates that the plan and CBH will collaborate to monitor for improvement to physical health resulting from behavioral health integration. The plan has implemented a shared platform, TruCare, that both physical health and behavioral health case managers can access, which allows them to collaborate as per onsite staff. The Program Description also notes that the plan will monitor medical and behavioral health coordination of care by monitoring information exchange through medical record review, monitoring behavioral pharmaceutical prescribing by primary care providers (PCPs), reviewing PCP guidelines for management and referral of behavioral health conditions, and	

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			monitoring claims for behavioral health referrals. The QI Work Plan notes that development of these metrics is in process. Cenpatico submitted its QI program documentation. The QI Work Plan, section on Coordination, describes the collaborative PIP in process for screening pregnant and postpartum women for depression, which is in process in CYs 2012 and 2013.	
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		Full	The QI Work Plan includes an annual review of the overall effectiveness of the QI Program. The 2011 QI Program Evaluation was targeted for completion on 7/30/12. The QAPI Program Description notes that the Evaluation will include an assessment of overall effectiveness of the program and completed and ongoing QI activities, trending of measures, interventions and their effectiveness, analysis and recommendations. The QI Program Evaluation was presented to the QIC as per minutes of 7/31/12; this Evaluation was limited to two months of	

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quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report by July 31 of each contract year.			the plan's operation, and was not provided for review. As per QIC minutes, the Evaluation included demographics, the QI Program and goals and objectives.	
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.		Substantial	The QAPI Program Description includes participation in External Quality Review (EQR) activities. The QI Work Plan includes the annual EQR as an activity, with the Quality Improvement Department designated as responsible for coordinating data requests. The plan provided most of the requested information for the annual compliance review; some information, such as Health Risk Assessment files, was not provided for onsite review. The plan provided PIP proposals as requested for PIP validation. **Recommendation for KY Spirit** The plan should provide requested documentation in a timely fashion for	**MCO Response:** As KSHP is not aware of requests for information by the IPRO that was not met in a timely manner. Please provide specifics defining the date the request was made by the IPRO and the response date to provide clarification for KSHP. **IPRO Comments:** No change in review determination. As stated, several documents required for the compliance review were not available at the time of the review.

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			future reviews.	
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.		Full	An annual EQR has not yet taken place, but the plan provided documents for the QAPI program evaluation and Annual Compliance Review and made staff available for the onsite meetings as requested. In addition, the plan participated in calls to discuss revision to the submitted PIP proposals as requested and is working to report the Healthy Kentuckians performance measures for CY 2012 in 2013.	
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.		Substantial	KY Spirit has cooperated with all EQR activities to date. The plan provided most of the requested information for the annual compliance review; some information, such as Health Risk Assessment files, was not provided for onsite review. **Recommendation for KY Spirit** The plan should provide requested documentation in a timely fashion for future reviews.	**MCO Response:** This section is a duplicate of 21.3. As KSHP is not aware of requests for information by the IPRO that was not met in a timely manner. Please provide specifics defining the date the request was made by the IPRO and the response date to provide clarification for KSHP. **IPRO Comments:** No change in review determination. As stated, several documents required for the compliance review were not available at the time of the review.
The Contractor shall assist the EQRO in competing all		Substantial	As above, the plan assisted in EQRO	**MCO Response:** This section is a duplicate of 21.3. and 21.4.

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Contractor reviews and evaluations in accordance with established protocols previously described.			reviews and evaluation. Some requested documents and files were not provided. **Recommendation for KY Spirit** The plan should provide requested documentation in a timely fashion for future reviews.	As KSHP is not aware of requests for information by the IPRO that was not met in a timely manner. Please provide specifics defining the date the request was made by the IPRO and the response date to provide clarification for KSHP. **IPRO Comments:** No change in review determination. As stated, several documents required for the compliance review were not available at the time of the review.
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:		NA	EQR annual compliance review is in progress. KY Spirit submitted a revised PIP proposal after the onsite review (3/25/13) that addressed the requested revisions.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;		NA	EQR compliance review findings have not yet been provided to the plan. The QAPI Program Description identifies the QI Director as responsible for implementing actions related to review findings.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and		NA	EQR compliance review findings have not yet been provided to the plan. The QAPI Program Description notes that findings will be presented to the QI/UM Committee, and the committee will review findings and provide input on corrective	

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			actions. The Annual Compliance Review, data collection for HEDIS 2013, reporting performance measures, and conduct of PIPs is in progress. Evaluation to be conducted.	
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.		NA	Annual EQR Compliance Review in process.	
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and		NA	Annual EQR Compliance Review in process.	
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	Annual EQR Compliance Review in process.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that		Full	The plan submitted a written QAPI Work Plan (2011/2012 QI Work Plan) and has submitted narrative updates for Q1, Q2,	

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			Q3 and Q4 2012.	
outlines the scope of activities and		Full	The QI Work Plan includes activities to be conducted.	
the goals,		Full	The QI Work Plan includes quantifiable goals with benchmarks for activities where applicable, with other activities referring to NCQA or the contract (access) for goals or noting that 2012 is a baseline year (PIPs).	
objectives, and		Full	The QI Work Plan includes objectives for each activity.	
timelines for the QAPI program.		Full	Reporting frequency and target completion dates are included in the QI Work plan.	
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.		NA	The QAPI Program Description refers to revised goals based on review of findings. The QI Work Plan notes that the Work Plan is continually updated. There are few findings available as of yet, as the plan has not yet reported annual measures, or received findings from the EQR review. The CAHPS survey was completed in 2012 and results presented in quarterly reports. The provider	

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			satisfaction survey was conducted in Fall 2012. QIC meeting minutes show discussion of performance and sub-committee reports and actions to be taken.	
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	QIC meeting minutes of 7/31/12 note approval of the 2012-2013 QAPI Program Description and QI Work Plan. Approval of the 2011-2012 QAPI Program Description is not documented in documents provided. **Recommendation for KY Spirit** The plan should provide evidence of approval of the 2011-2012 QAPI Program Description.	**MCO Response:** The 2011 Program Description was approved prior to start-up and is evidenced in the August 18, 2011 minutes of the QI Committee. These QI minutes and the Program Description were presented to Medicaid at the readiness review that occurred in 2011. KSHP was not aware that IPRO was in need of these minutes as this was prior to the November timeframe. This was outside of the IPRO designated review timeframe and no requests were made at the time of the on-site review. The QI Committee August 18, 2011 minutes are attached for your review. As these minutes provided evidence of the review of the 2011 -2012 QI Program Description, the Plan requests this element be revised to reflect full compliance. **IPRO Comments:** Review determination changed to Full. The 2011-2012 Program Description was approved in August 2011.
designation of an accountable entity within the organization to provide direct oversight of QAPI;		Full	The Kentucky Spirit Health Plan (KSHP) Board of Directors has ultimate authority and accountability for oversight of quality of care and services provided to members as per the Program Description. Operating	

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			authority is delegated to Quality Improvement/Utilization Management Committee (QI/UMC). This committee is referred to in minutes and elsewhere as the Quality Improvement Committee (QIC), which appears to have been merged with the Utilization Management (UM) Committee in consideration of providers' time as per meeting minutes. The title of this committee varies across documents.	
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	Four documented QIC meetings provided. These provide evidence of review and approval of the QI Work Plan, QI Program Evaluation, and CAHPS survey results.	
review on an annual basis of the QAPI program; and		Full	The QI Program Evaluation was reviewed at the 7/31/12 QIC meeting. The QI Program Evaluation for 2012 was not available for review yet.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.		Full	The QAPI Program Description refers to revised goals based on review of findings. The QI Work Plan provided does not include status updates on activities. Updates of status of QI activities are provided in narrative form in quarterly reports #17 (QAPI Work Plan Update), #16 (Summary of QI Activities) and # 24 (activities relevant to EPSDT, pregnant	

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			women and maternal and infant death). The quarterly reports include descriptions of activities and programs initiated based on review of findings such as preterm birth and low birth weight births, EPSDT screening rates, and a program based on pharmaceutical data for pregnant women (vitamins, narcotics and teratogens) called BabySteps, for which interventions are being planned.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.		Full	The QI/UMC has been delegated operating authority for the QAPI Program as noted in the Program Description (previously the QIC committee).	
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.		Substantial	As per the QAPI Program Description, the QI/UMC is comprised of senior management staff, clinical staff and network providers including but not limited to primary care, specialty care, behavioral health , dental and vision providers. The Program Description also notes that other high volume specialists may be added as appropriate, but at least one will be a behavioral health provider. As per the Program Description, the QI/UMC is supported by committees that include the Pharmacy and Therapeutics (P	**MCO Response:** Kentucky Spirit Health Plan's QIC includes representation from the following specialties: Behavioral Health, Emergency Medicine, Internal Medicine, OB/GYN, and Pediatrics. These specialties represent the highest-volume provider types within our network and their inclusion provides appropriate and adequate representation from a provider basis. The committee's quick reference guide includes the membership of the QIC and was submitted to the IPRO as part of the required documentation prior to the on-site review. As evidenced above, the Plan believes that this measurement standard was satisfied and requests this element be revised to reflect full compliance.

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			and T), Utilization Management, Credentialing, Peer Review, Grievance and Appeals, Joint Operations, Member Advisory, Physician Advisory and Community Advisory Committees and the Performance Improvement Team. The QIC membership as listed in the first quarterly report #21 "Committee Activity" includes five network providers representing pediatrics (3) and Emergency Medicine (2); a behavioral health provider is not noted. The P and T committee includes pharmacy as well as physician representation. Discussion at QIC meeting of July 2012 notes the intent to combine QIC and UM to better utilize providers. Quarterly Report #21 includes meeting summaries of the QIC, Credentialing and P and T committees as well as a Lock-in Review Committee, HEDIS Steering Committee, Community Advisory Committee and Member Advisory Committee. **Recommendation for KY Spirit** The MCO should ensure that all specialties are represented on the QIC, as stated in the committee description.	**IPRO Comments:** No change in review determination. The Quick Reference Guide does not indicate specialties. The present/absent member list included in committee minutes do not demonstrate representation of all the specialties noted in the MCO's response.
The committee shall meet on a regular basis and		Substantial	The QI Work Plan indicates that the QIC	**MCO Response:** Duplicate of 19.1 regarding meeting

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activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.			will meet quarterly. The QAPI Program Description notes that all committee activities are documented in minutes in a standard format developed by the plan. Minutes were provided for three QIC meetings only, (February, July and December 2012). Committee summaries were provided in quarterly reports as noted above. **Recommendation for KY Spirit** KY Spirit should ensure that the QIC meets per the committee charter.	frequency. KSHP agrees that QI activities are ongoing and that committee meetings occur per policy each quarter. However, 2012 was the start-up year for the Plan. As the startup year, some committees did not meet on their established basis due to other Plan activities. Since 3rd quarter 2012, this committee has met quarterly as per the QAPI Program Description. **IPRO Comments:** No change in review determination.
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.		Full	Per onsite staff, vendor oversight is conducted weekly to monthly, with the plan meeting at least quarterly with subcontractors and meetings and agenda items added as needed. Quarterly reports # 15 documents monthly meetings and monitoring of complaints and contract and compliance metrics. Subcontractor appeals are monitored by the plan and reviewed by the medical director, as per onsite staff. Onsite staff indicated that numerous variables relevant to appeals and grievances are monitored. Onsite staff reported an issue with turnaround times on subcontractor appeals, and a number	

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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
			of fair hearings for behavioral health services. Reports are generated regarding whether standards were met, and currently monthly metrics are being collected. The Joint Operations Committee sets priorities for QI initiatives based on monthly metrics as per the Program Description and onsite staff. Monitoring of dental timeliness of authorization for prior authorizations and appeal turnaround times are ongoing. A Corrective Action Plan for MCNA, the dental vendor, was reported due to various performance issues in quarterly reports, and these reports document ongoing monitoring of improvement. Annual reviews are conducted for subcontractors as per onsite staff.	
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.		Full	Per the QAPI Program Description, quality is integrated in departments across the plan. The QIC Committee includes senior management staff from Medical Management, Network Development, Contracting, Member Services, Provider Services, Compliance and Quality Improvement as well as the Medical Director. UM activities and Grievances and Appeals monitoring are evident in	

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			documents provided, as well as adverse event (risk management) monitoring. Onsite staff report that there are many cross-department initiatives. QIC minutes demonstrate reports from sub committees to the QI committee.	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of Member's care and services, including those with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.		Full	As per the QAPI Program Description and a staffing model provided by the plan, staffing is based on plan membership, with fixed and also variable membership-driven positions. The plan is approved for 186 positions according to onsite staff. The staffing model and organizational chart provided by the plan include fixed positions for the Director of Quality Improvement, described as a nurse or otherwise qualified person who is responsible for directing activities of quality management staff in monitoring and auditing the plan's health care delivery system. The Chief Medical Director (full time per onsite staff) with supporting Medical Directors (3 per the organizational chart, one full time as per onsite staff) are responsible for core benefits and services provided to members, quality management, utilization management and the grievance system.	

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			The Program Description identifies an NCQA/HEDIS Project Manager who maintains documentation to support State contract requirements and NCQA standards; the staffing model and organizational chart reference a HEDIS Coordinator. Staffing includes a Vice President of Compliance, a position that onsite staff identified as responsible for ensuring appropriate reporting. Quality Improvement Coordinators conduct quality improvement activities-the organizational chart identifies one QI Coordinator. Staffing also includes Vice President of Medical Management, Vice President of Contracting and Network Development, Chief Operating Officer, who is responsible for ensuring the local claims system is appropriate for Kentucky per onsite staff, and a Vice President of Compliance. The plan's organizational chart includes a Dental Director, Pharmacy Director and Director of Behavioral Health. The organizational chart includes a Director of Member/Provider Services, Director of UM, Director of Case Management, an EPSDT Coordinator, a Guardianship-Foster Care Liaison, and the	

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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**
			position of Vice President of External Relations. The organizational chart documents 22 case managers, 20 UM referral specialists, and many additional staff including member and provider services representatives, program coordinators and member connections staff. Onsite staff indicated that there were case management teams addressing obstetrics, and Emergency Department utilization, and that there was a quality group identified within Medical Management. Two open positions were noted: Director, QI and Director, Provider Relations. The VP of Medical Management is serving in the role of Director of QI.	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice		Full	The QAPI Program Description documents that the plan monitors preventive, acute, chronic and behavioral health care; continuity and coordination; delegated services; department performance and services; cultural competency; member enrollment/ disenrollment; member and provider complaints , grievances and	

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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.			satisfaction; safety; Primary Care Provider (PCP) changes; pharmacy ; access; credentialing; and utilization. The QI Work Plan documents ongoing or planned activities to evaluate delegated services, compliance with medical record standards and clinical guidelines, quality of care concern trends, HEDIS indicators, member complaints and grievances, credentialing indicators, utilization including pharmacy, and access and availability of providers. The Work Plan and onsite staff indicates that the plan is monitoring non-audited HEDIS measures at this time. As per the second quarterly report, these preliminary rates were reviewed by the HEDIS Steering Committee and areas for improvement identified. These areas were identified as Women's Health Screenings, Well Child Visits, Adolescent Well Care Visits, Childhood Immunizations, and Comprehensive Diabetes Care. The QI Work Plan indicates that the plan is establishing metrics for monitoring continuity and coordination of care and effectiveness of case management and disease management programs. There is evidence of monitoring of EPSDT screens	

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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
			in the first quarterly report. The plan used historical data in Impact Pro to identify members with care gaps or special needs and risk. Data are evaluated for individual and population based risk, and needed interventions such as case management. The plan is evaluating access through Geo Access reports and access and availability phantom call surveys. As per the QAPI Program Description, compliance with preventive and clinical practice guidelines is a goal for the program. Quarterly reports document adverse event monitoring for both physical health and behavioral health. The plan is monitoring ED utilization as per quarterly reports, and has implemented a program to receive daily notification from facilities and then outreach to members seen in ED as per onsite staff. The plan is also monitoring readmissions and has implemented a program to establish contact with members post discharge. The plan has already conducted Adult and Child CAHPS surveys, and findings were discussed in committee. The plan is in the process of data	

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			collection for HEDIS 2013 (CY 2012) reporting, calculating KY Performance Measures, as well as audit of provider compliance with Clinical Practice Guidelines. The plan provided reports for the Provider Satisfaction Survey, Evaluation of Pharmacy Performance Measures and minutes for the Appeals and Grievance Committee, P & T Committee, Lock In Committee, Community Advisory Committee, Credentialing Committee, and HEDIS Committee.	
B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.		Full	The QAPI Program Description documents compliance with preventive and clinical practice guidelines as a goal, with an aim to monitor until 90% of providers are consistently in compliance. The Program Description includes Physician Profiling relevant to guidelines, and notes that measurement of compliance with two components of four clinical guidelines will be conducted annually. HEDIS measures are used for monitoring when possible. The plan monitors asthma, diabetes, adult and child preventive care, antepartum care, ADHD and depression guideline compliance. The second quarter report 23	

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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
			"Evidence Based Guidelines for Practitioners" indicates that the plan is developing provider worksheets and educational material associated with the guidelines. Monitoring of compliance with behavioral health guidelines is delegated to Cenpatico. The 3Q 2012 QIC meeting minutes indicate that the plan intended to evaluate guidelines for Sickle Cell Disease but due to the low prevalence among members, decided to choose another guideline. No further information was found in the December 2012 QIC meeting minutes. Cenpatico provided the report for its assessment of compliance with practice guidelines. CBH uses the HEDIS measures for antidepressant medication management and follow up for ADHD medication.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.		Full	A Corrective Action Plan (CAP) was noted in quarterly reports to be in place for MCNA, which provides dental services, based on identified performance issues that included authorization turnaround. Interventions implemented based on	

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			identification of needed improvement from evaluation of other data are noted above in section 19.1 and 19.4a.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.		Full	Quarterly reports document ongoing monitoring of the CAP for MCNA.	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.		Full	The QIC is comprised of a multidisciplinary team as described above, and quality evaluation findings are presented to this body. The HEDIS Steering Committee, which oversees the HEDIS process including data concerns and rate trending, includes the Medical Director, the VP of Medical Management, the Chief Operating Officer, the VP of Network Development, the Director of Quality Improvement, the Director of Case Management, and the HEDIS Coordinator. The QAPI Program Description indicates that the Management Information System (MIS) supports the QAPI program, and that data and analytic support is provided by the Information and Management Systems Department, Corporate Quality Improvement and Health Economics, and other corporate and plan staff as needed.	

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D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.		Full	The plan submitted and resubmitted PIP proposals as requested, and has submitted quarterly reports as requested. The Cervical Cancer Screening proposal was approved. An updated proposal for the Screening for Depression in Prenatal and Postpartum Women PIP was provided onsite and discussed with KY Spirit and CBH. The revised proposal was submitted on 3/25/13 and included the requested revisions.	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.		Full	The QI Program Description includes a description of the development and dissemination of preventive and clinical practice guidelines, which are distributed to affected providers and to members upon request. Clinical practice guidelines for at least two acute or chronic medical conditions and at least two behavioral health guidelines relevant to plan membership are adopted. At least two must correspond with disease management. Guidelines are available on the KY Spirit website via link or full guideline; the website is updated annually. The QI Work Plan includes Preventive Health And Clinical Practice Guidelines as	

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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
			activities, and notes that adoption and review of Preventive Health And Clinical Practice Guidelines are outlined in policy KY.QI.08.	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;		Full	The QI Program Description indicates that guidelines will be evidence based. The second quarterly report #18, Monitoring Indicators, Benchmarks and Outcomes, notes that nationally-developed guidelines can serve as the foundation of guideline development, and list potential sources including American Medical Association, specialty societies such as the American Academy of Pediatrics (AAP), AHRQ, and the US Preventive Services Task Force (USPSTF). Examples of guidelines adopted by KSHP include the ADA guidelines for management of diabetes, NHLBI NAEP guidelines for asthma management, and AAP/Bright Futures Pediatric EPSDT and immunization schedules.	
consider the needs of Members;		Full	Per the QI Program Description, development of guidelines is based on the health needs of members and identified opportunities for improvement. The	

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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
			second quarter report 23 "Evidence Based Guidelines for Practitioners" notes that claims data are being reviewed to identify whether guidelines selected are congruent with the plan's population; these currently include Adult and Pediatric Preventive, Asthma, Diabetes, and Sickle Cell. QIC minutes include discussion of selection of Sickle Cell as a topic for guideline development, and need to consider the plan's population in choosing a focus, since there are few members with Sickle Cell Disease.	
developed or adopted in consultation with contracting health professionals, and		Full	The QI Program Description indicates that guidelines will be adopted in consultation with network providers, including behavioral health as applicable. Guidelines were discussed in QIC as noted above, and QIC includes network providers.	
reviewed and updated periodically.		Full	The QI Program Description indicates that guidelines will be updated if there is significant new evidence or change in national standards, or at least every two years.	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.		Full	The QI Work Plan notes that medical necessity decisions are made with evidence based criteria. The QI Program	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Description notes that adopted guidelines are tied to disease management programs.	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.		Full	The plan documents two pharmacy programs in quarterly reports, including BabySteps to monitor pharmaceuticals in pregnancy, which the plan notes is a factor in subsequent medical costs. The other identified program, Community Mental Health Facility Pharmacy Utilization Outreach, monitors prescribing patterns for behavioral health medications and gives feedback to the facilities for improvement initiatives to be identified. The plan notes a reduction in Behavioral Health costs in the second quarterly reports, although this is not quantified. The plan provided a summary of the innovative programs. These included: Start Smart Substance/Teratogenic Use Program; Emergency Room Case Management Program; Readmission/Discharge Planning Case Management Program; Health Outcomes Improvement Program (HEDIS performance); CMHC Pharmacy Utilization	

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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**
			Outreach (prescribing patterns); BH/KVC-Wrap Around Pilot (improve support for members and avoid out of home placement); BH Pilot: Increasing Community Capacity for High Level Needs Youth in Foster Care (expand therapeutic foster home capacity/movement out of PRTFs and inpatient settings).	
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix O, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.		Full	The QI Work Plan indicates that baseline review of HEDIS data was conducted in 2012, and interventions were identified. The plan has not yet formally reported performance measures. Data collection for HEDIS 2013 and KY Health Outcomes measures is in progress. Year to date HEDIS data was reviewed on an ongoing basis.	
Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record		NA	NA; measures not yet reported.	

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data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.				
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.		NA	The plan received the ISCHN measure specifications and is in the process of calculating the measures. The plan submitted appropriate questions regarding the specifications.	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.		NA	NA; health outcome measures have not yet been reported.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.		NA	NA; goals and targets not yet set by the Work Group. The plan reports activities in quarterly reports #16 Summary of Quality Improvement Activity and #17 Quality Assessment and Performance Improvement Work Plan. The 2011/2012 QI Work Plan demonstrates updates for each quarter. As noted previously, the plan is currently collecting data and calculating performance measures.	
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report		NA	The plan has not yet reported annual	

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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.			HEDIS data, which will be reported in 2013.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.		NA	NA; measures not yet reported.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.		NA	NA; measures not yet reported.	
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		NA	NA; measures not yet reported.	

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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.				
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.		NA	NA; measures not yet reported.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.		NA	The plan has not yet undergone NCQA accreditation.	
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		NA	The plan has not yet undergone NCQA accreditation; the 2011-2012QI Work Plan includes NCQA accreditation as an activity, with target completion of 2-4 years post	

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four (4) years from the effective date of this contract.			"go live" date. The plan has conducted a baseline assessment relevant to NCQA guidelines for accreditation as per the QI Work Plan.	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed.		Full	The topics for the original PIP proposals were not accepted by DMS, and a resubmission date of 10/19/12 was established. The PIP proposals re-submitted address Prenatal and Postpartum Depression Screening and Management and Cervical Cancer Screening. While initially the Cervical Cancer Screening PIP did not clearly identify the relevance of the topic to plan membership, the revised PIP includes strong rationale with clear relevance to the plan's population. The Cervical Cancer Screening PIP proposal was approved. The Depression Screening for Prenatal and Postpartum Periods proposal was resubmitted on 3/25/13 and addressed the requested revisions.	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential		Substantial	Although the plan is monitoring performance, baseline data was lacking regarding rates of cervical cancer	**MCO Response:** The baseline measure is defined in the document as the first year HEDIS measure and is based on HEDIS specificity. HEDIS data was not pulled until 2013 and

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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**
improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to members and providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.			screening when the PIP proposal was developed, although the plan noted the proportion of members who would be eligible for the service (30% of 55% of total membership). The plan did not have baseline data for depression screening among pregnant and postpartum women when the PIP proposal was developed, but noted low numbers of women participating in depression screening (5% prenatal and 10% postpartum) and behavioral health services (33% of those contacted with moderate or high risk). The plan provided other evidence of the prevalence of depression during the perinatal period, and its associated risk. **Recommendation for KY Spirit** KY Spirit should be sure to provide supporting evidence to demonstrate how the PIPs are expected to have a positive effect on health outcomes and/or member satisfaction.	the Plan has just received the final locked results. DMS approved this PIP in 2012 without baseline data. The Plan believes this should be moved to full compliance based on the timing needed to obtain baseline data and the prior approval of the IPRO and DMS of the original document. Based on the information provided and the prior approval of these documents, the Plan requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination. The PIP was still under revision through March 2013.
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.		Full	The plan has established a Community Advisory Committee. Members include Public Health Directors, Homeless and Housing Coalition of Kentucky, Children's	

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Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.			Alliance, Coordinator of Family Resource Centers, Chrysalis House (substance abuse treatment for women), National Alliance on Mental Illness (NAMI) and the Urban League of Fayette County. Onsite staff indicated that the plan had partnered with local health departments for flu vaccine outreach, and had been establishing collaborative relationships with school nurses. Meeting minutes for the Community Advisory Committee for July and December 2012 were provided.	
The Department and the Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures.		Full	The plan has cooperated with the Department in development of PIP proposals and submission of quality improvement activities in quarterly reports.	
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.		Full	The topics for the original PIP proposals were not accepted by DMS, and a resubmission date of 10/19/12 was established. The plan's resubmitted PIPs address one physical health and one behavioral health condition: Cervical Cancer Screening and Prenatal and Postpartum Depression Screening and	

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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
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.			Management. These topics were accepted by DMS.	
The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix N.		Full	The plan's chosen PIP topics are consistent with two of the four clinical topics identified by the Department (Depression and Screenings for Breast Cancer, Cervical Cancer and Chlamydia). The MCO chose topics are Prenatal and Postpartum Depression Screening and Cervical Cancer Screening.	
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:		Full	The plan submitted the two PIP proposals on the template provided by the Department.	
A. Topic and its importance to enrolled members;		Substantial	The plan established the relevance of the topics to the plan's membership in the PIP proposals submitted.	**MCO Response:** Please be more specific as the Plan has the reviewed the original submissions and does not recall needing assistance with establishing the relevance of the topic to the

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
			KY Spirit required assistance to select topics and provide supporting rationale acceptable to DMS. **Recommendation for KY Spirit** The plan should ensure the relevance of selected topics to its enrolled population.	Plan's membership. The IPRO's proposal comments on the Improving Cervical Cancer Screening Rates and Prenatal and Postpartum Depression Screening and Management PIPS stated that relevance of the topic for the population was strong and clear. The IPRO listed this as a strength on both document proposal comments. As evidenced above, the Plan believes it has met the standard requirement and requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination. The original PIP proposal rationale was not specific for cervical cancer. It was revised following a technical assistance conference call with IPRO/DMS.
B. Methodology for topic selection;		Substantial	The rationale for topic selection in the resubmitted PIPs includes clinical rationale and population relevance; baseline data were not available for the topic selection. **Recommendation for KY Spirit** The plan should ensure the relevance of selected topics to its enrolled population.	**MCO Response:** The IPRO's proposal comments on the Improving Cervical Cancer Screening Rates and Prenatal and Postpartum Depression Screening and Management PIPS stated that relevance of the topic for the population was strong and clear. The IPRO listed this as a strength for our original submissions on both document proposal comments. As evidenced above, the Plan believes it has met the standard requirement and requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination. Although the PIP topic was approved, the PIP proposal,

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				including rationale, required revisions.
C. Goals;		Substantial	The Cervical Cancer Screening PIP included a goal for improvement; the Depression PIP did not include a goal for improvement. **Recommendation for KY Spirit** The plan should establish goals for each project.	**MCO Response:** The Plan did not include a goal on the Depression Screening PIP as there was a need to establish a baseline prior to defining the goal. One was established for Cervical Cancer Screening as the Plan had done some claims analysis to determine compliance. **IPRO Comments:** No change in review determination. Although baseline data was not available, the MCO could have established a goal, such as X% improvement from baseline.
D. Data sources/collection;		Full	The plan clarified data sources and collection procedures in PIP proposals resubmitted.	
E. Intervention(s) – not required for projects to establish baseline; and		Substantial	Interventions were relevant to the topic in both resubmitted PIP proposals, but required clarification and revisions continue for the Depression Screening PIP proposal. **Recommendation for KY Spirit** The plan should clarify interventions for the Depression Screening PIP proposal.	**MCO Response:** As the IPRO has made suggestions the Depression Screening PIP has been revised to include those suggestions. In February DMS had indicated that this PIP was approved and requested our signature page. This was submitted to Betty Barber but she did not return with a signature after indicating it was approved. As evidenced above, the Plan believes it has met the standard requirement and requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
F. Results and interpretations – clearly state whether		NA	Results are not yet available for the PIPs.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
performance goals were met, and if not met, analysis of the intervention and a plan for future action.				
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;		NA	NA; proposals only submitted.	
B. Did Members participate in the performance improvement project?		NA	NA; proposals only submitted. However, interventions are targeted to members in both PIPs.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;		NA	NA; proposals only submitted.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;		NA	NA; proposals only submitted.	
E. Is there an executive summary;		NA	NA; proposals only submitted.	
F. Do illustrations – graphs, figures, tables – convey information clearly?		NA	NA; proposals only submitted.	
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms		Full	The resubmitted PIPs include a standard HEDIS indicator for the Cervical Cancer Screening measure, and the plan identifies the NCQA 2012 90th percentile as the benchmark, with a goal for 10%	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
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			improvement as noted above. While not using standardized indicators for the Depression Screening and Management PIP, the plan is developing indicators to reflect standardized screening with the Edinburg screening tool, and engagement in behavioral health services for those at risk. The plan identified benchmarks from other Centene health plan 2011 best rates. The plan did not yet establish goals; the PIP is still being revised.	
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:		NA	NA; proposals only submitted.	
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.		Full	The plan's initially submitted PIPs were timely.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.		NA	NA; proposals only submitted.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.		NA	NA; proposals only submitted.	

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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**
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.		NA	NA; proposals only submitted.	
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.		Full	The QAPI Program Description includes a Member Advisory Committee and notes that ad hoc committees may include regional level committees for Member Advisory and/or Community Advisory committees based on membership distribution. The Program Description notes that the purpose of the QMAC is to solicit member input into the Quality Improvement Program. The plan has also designated a Community Advisory Committee that includes representatives from community based organizations, advocacy groups, church leaders and other community based organization.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Responsibilities of the Committee shall include:		Full	As per the QAPI Program Description, the QMAC includes members, parents/foster parents/guardians. Quarterly Report 21 for second quarter 2012 identifies a meeting of the QMAC for the first time on June 13, 2012. Two plan members attended the meeting, with plan staff comprising the rest of the attendees.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Further information regarding the characteristics of these members such as aid category was not provided. The plan also noted a first meeting of the Community Advisory Committee on April 5, 2012. Members included Public Health Directors from two counties, Homeless and Housing Coalition of Kentucky, Children's Alliance, Coordinator of Family Resource Centers, Chrysalis House (substance abuse treatment for women), National Alliance on Mental Illness (NAMI) Meeting minutes for the QMAC were provided for June and November 2012. Committee members included women of child-bearing age whose children were also members, women with chronic conditions, and a grandparent member. Meeting minutes for the CAC were provided for July and December 2012.	
A. Providing review and comment on quality and access standards;		Minimal	Quality and access standards review and comment are within the scope of the QMAC as per the QAPI Program Description. QMAC minutes did not provide evidence of review of quality and access standards.	**MCO Response:** KSHP agrees that the MAC should conduct activities per the committee charter. However, 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the Plan During the second meeting access to care was discussed and is documented in the minutes.

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The meetings held focused on member feedback regarding their experience with the plan and any barriers they experienced. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	As this meeting evidenced review and discussion of access to care, the Plan believes it has met the standard requirement and requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;		Minimal	Review and comment on processes as well as data driven modifications for Grievances and Appeals are within the scope of the QMAC as per the QAPI Program Description. The minutes did not provide evidence of review of grievance and appeals processes. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR	**MCO Response:** KSHP agrees that the MAC should conduct activities per the committee charter and QI Program Description. However, 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the Plan and presented QI Plan programs, such as Member Connections and Connections Plus Program. The 2012 results for grievances and appeals were not ready until 1st qtr. 2013 and will be presented to the MAC committee in 2013. **IPRO Comments:** No change in review determination.

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
			Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
C. Review and provide comment on Member Handbooks;		Minimal	Review and comment on Member Handbooks are within the scope of the QMAC as per the QAPI Program Description. The minutes did not provide evidence of review of the Member Handbook. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the Plan. The Member Handbook was required by DMS to be complete at readiness review which was prior to the Plan Nov. 2011 start-up. As the requirement was prior to having members, the Plan was unable to have a review of the handbook. As the handbook is updated, this information will be brought to the MAC. **IPRO Comments:** No change in review determination.
D. Reviewing Member education materials prepared by the Contractor;		Minimal	Review of member education materials is within the scope of the QMAC as per the	**MCO Response:** 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			QAPI Program Description. The minutes did not provide evidence of review of Member materials. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Plan. Member educational material was prepared and submitted to DMS prior to start-up. For 2013 the Plan will bring member educational material to the MAC. **IPRO Comments:** No change in review determination.
E. Recommending community outreach activities; and		Minimal	Recommending community outreach activities is within the scope of the QMAC as per the QAPI Program Description. The minutes did not provide evidence of review of community outreach activities. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that	**MCO Response:** 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the Plan. In 2013, the Plan will solicit input from the MAC on community outreach activities. **IPRO Comments:** No change in review determination.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.		Minimal	Review and comment on plan and Department policies, as well as other topics identified by the QI/UMC are within the scope of the QMAC as per the QAPI Program Description. The minutes did not provide evidence of review of polices that impact Members. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** 2012 was the start-up year and the Plan used the committee meetings to introduce the members to the Plan. In 2013, the Plan will solicit input from the MAC on community outreach activities requests review and feedback from the MAC on Contractor and Department policies. **IPRO Comments:** No change in review determination.
The list of the Members participating with the QMAC shall be submitted to the Department annually.		Full	Members participating in the QMAC meeting were included in second quarterly reports.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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 QI Work Plan includes conduct of a member satisfaction (CAHPS) survey that was completed in 2012. The provider satisfaction survey was conducted in the Fall of 2012.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.		Full	The CAHPS survey results and comments were provided in quarterly reports.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.		Non-Compliance	The plan did not indicate that assessment for the need for special surveys was conducted, although behavioral health survey, MHSIP, was in process. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends	**MCO Response:** As 2012 was a start-up year, baseline data was being gathered. Now that the Plan has had one full year of operations, data will be reviewed and the need for special surveys with be assessed. **IPRO Comments:** No change in review determination.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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 plan submitted the MHSIP Consumer Survey Instrument in second quarterly reports.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.		Full	Provider satisfaction survey was conducted in Fall of 2012.	
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.		Full	The plan submitted survey results for Adult and Child surveys in the second quarterly report and the tool for the MHSIP.	
All survey results must be reported to the Department, and upon request, disclosed to Members.		Full	Results were submitted in second quarterly report as above.	
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		Full	The plan submitted a Summary of Quality Improvement Activities and Quality Improvement Work Plan to the Department in first and second quarterly	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.			reports. Q3 and Q4 2012 quarterly report were not submitted with the documentation for review.	
Reference the following documents for further information: **Appendix K** **Appendix N** **Appendix O**				

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Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	56	12	6	1
Total Points	168	24	6	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		**198/75=2.64**		

Reviewer Decision:

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

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Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

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

Reports

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

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

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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**
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.		Substantial	P/P KY.QI.11, Grievance /Appeals System Description and Work Process KY.QI.11.01, Grievance Process provided. The Work Process is not clear as it appears to address both grievances and appeals, but these are not sufficiently distinct in the procedure, e.g., the terms are used interchangeably despite some of the time frames differing, and reference is made to the fair hearing process. Note that the Member Handbook provides distinct instruction for each. **Recommendation for KY Spirit** KY Spirit should clarify its Work Process by either creating distinct sections/procedures for grievances and appeals or by creating a Work Process for each.	**MCO Response:** None
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.		Minimal	P/P KY.QI.11 and the Member Handbook delineate the processes for grievances and appeals individually and describe the processes for filing with the MCO or for a State Hearing. P/P KY.QI.11.01 addresses grievances and	**MCO Response:** P/P KY QI.11 addresses this requirement. The policy states "A member, legal representative(s) of a deceased member's estate, or an authorized representative of a member acting on their behalf (with written consent from the member) may file a grievance, appeal or State

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
			appeals, but is not sufficiently clear as noted above. At the onsite review, the MCO indicated that a member inquiry is only considered a grievance if it cannot be resolved within 24 hours. This is not stated in the Grievance and Appeal System P/P or in the Work Process. In addition, the DMS Contract does not contain a provision for this and it does not appear that the MCO obtained approval from DMS for this policy prior to implementation. It also appears that cases handled as inquiries are not included in the tracking and trending of grievances. KY Spirit should assure that policies/procedures accurately describe the process in place. The MCO should obtain DMS approval for processing grievances in a manner that is inconsistent with the contract requirements. Inquiries should be categorized by reason, tracked and trended. In analyzing grievance data, the MCO should include inquiries in like categories in order to	Fair Hearing on behalf of a member. The legal guardian of a minor or incapacitated adult may also file a grievance, appeal or request for a State fair hearing." It also states: "A provider, acting on behalf of the member (with the member's written consent), may file a grievance, appeal or State Fair Hearing on behalf of a member." It also states these must be filed within thirty (30) days of the action. The P/Ps also states that the requests may be oral or in writing. The P/Ps states that the appeal may be received by the Member Services Representative and indicates how the representative will forward the appeal to the Grievance and Appeals Coordinators. It states that the decision will be made within 30 days for a standard appeal and 72 hrs. for an expedited appeal. The policy also provides the information that a written resolution will be provided by the Plan. KSHP is unsure what other information the IPRO is requesting that is not clear and contained within the policy. KSHP has made multiple requests to have the

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
			identify areas for improvement and implement relevant interventions. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	written definition of a grievance and complaint addressed by DMS. During 4th quarter 2012, Rector & Associates were made aware of the inconsistencies among MCOs related to what is classified as a grievance vs. an complaint. Rector & Assoc. indicated they would make a request in writing to the DMS to have a written definition provided. KSHP staff met with April Lowry and Allyson Harris with the MCO Oversight Branch in February and a discussion was held regarding the lack of definitions. April and Allyson indicated they would provide a definition in writing to the Plan. In March of 2013, the lack of a written definition was discussed with the IPRO at their annual on-site review. At the exit conference they indicated they would work with DMS to obtain written definitions so there would be consistent data across MCOs. To date, KSHP has not received these written definitions. Based on the efforts of KSHP to obtain clarification and the documentation above of the information contained within the policy, the Plan requests a definition be provided for an inquiry, a complaint, and a grievance, to ensure consistent application among MCOs.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
				The Plan also requests that this be moved to full compliance as the Plan has clear information in the policy and has made at least three (3) efforts to get clear definitions from the State or its contractors. **IPRO Comments:** No change in review determination.
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 the Provider Manual.	
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.		Substantial	P/P KY QI.11.01 and the Member Handbook do not provide information on available assistance for members (interpreter, TTY/TTD, toll-free numbers). The Member Handbook has a statement "Contact Member Services at…if you need help. We can assist you in filing an appeal." **Recommendation for KY Spirit** KY Spirit should include information on available assistance for filing grievances/appeals in the Work Process and Member Handbook instructions for grievances and appeals.	**MCO Response:** Members are provided contact information for member Services at the bottom of every page in the member handbook. Each page reads: Kentucky Spirit Health Plan Member Services Department: 1-866-643-3153, TDD/TTY 1-855-790-5051, www.KentuckySpiritHealth.com. There are also section within the handbook devoted to available resources and assistance for members. Based on the information above, KSHP requests this be element be revised to reflect full compliance. **IPRO Comments:** No change in review

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**
				determination.
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.		Full	Work Process KY.QI.11.01 states that the Chief Medical Director and the Grievance and Appeal Coordinator maintain responsibility over the time frames. P/P KY.QI.11 states that the QI Program will review patterns/trends and initiate corrective actions when necessary.	
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:		Minimal	Addressed in P/P KY.QI.11. The Work Process does not address this requirement. None of the grievance files reviewed involved clinical issues. In the appeal file review, this was not evident due to incomplete documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or	**MCO Response:** The files did not contain a clinical issue, therefore the files cannot provide this documentation. The evidence of compliance is contained in KY.QI.11, the QI Program Description and the UM Program Description. Per P/P KY.QI.11 "Plan will ensure that decision makers on grievances and appeals were not involved in previous decision making and that all decision makers are health care professionals with clinical expertise in treating the member's condition ." KSHP believes that the policy and Program Descriptions demonstrate full compliance with this element and requests this be revised to reflect full compliance.

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**
			deficiency identified by the EQRO.	**IPRO Comments:** No change in review determination.
A. An appeal of a Contractor denial that is based on lack of medical necessity;		Minimal	Addressed in P.P KY.QI.11; the Work Process states that grievances related to medical necessity will be routed to the Medical Director for review. However, as noted previously, the distinction between grievances and appeals is not clear. In the appeal file review, this was not evident due to incomplete documentation. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** P/P KY.QI.11 has definitions within the policy that clearly define the difference in an appeal and a grievance. The policy states the definition are as follow: "Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or Plan employee or failure to respect the member's rights. Appeal: A formal request from a member to seek a review of an action taken by the Plan pursuant to 42 CFR 438.400(b). " KSHP has medical necessity appeals that were in the file review although some documentation was missing in some files, KSHP believes that the files demonstrate appeals for medical necessity. KSHP believes that the definitions contained in P/P KY.QI.11 demonstrate full compliance

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**
				with this element and requests this be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
B. A Contractor denial that is upheld in an expedited resolution; and		Minimal	Addressed in KY.QI.11. However, expedited resolutions are not addressed in the Work Process, particularly with regard to who will review these. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP believes this is fully addressed in P/P KY.QI.11 and there is not a need for additional documentation. The statement in policy KY.QI.11 applies to all grievances and appeals, regardless if they are expedited or standard. P/P KY.QI.11 states" Plan will ensure that decision makers on grievances and appeals were not involved in previous decision making and that all decision makers are health care professionals with clinical expertise in treating the member's condition ." Based on the information above, KSHP requests this be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
C. A grievance or appeal that involves clinical issues.		Minimal	Addressed in P/P KY.QI.11. The Work Process does not address grievances and appeals that involve clinical issues, only those related to medical necessity. The	**MCO Response:** This is addressed in the KY.QI.11. The Plan is unsure how clinical and medical are being differentiated by the IPRO as it relates to this element. Clinical is

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**
			section on "Resolution Letter" indicates that the qualifications of the reviewer will be provided in the letter if the grievance is related to clinical issues. None of the grievance files reviewed involved clinical issues. In the appeal file review, this was not evident due to incomplete documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	defined as related to symptoms and the course of a disease. The Plan reviews all clinical/medical issues as they relate to medical necessity. The Plan believes that the terms clinical issues and medical are synonymous. If a clinical/medical issue is being grieved or appealed, the information in P/P KY .QI.11 applies and the qualification of the reviewer would be contained in the letter as indicated by policy. The Plan believes that this requirement has been demonstrated by policy and requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
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		Full	Addressed in the Member Handbook.	

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**
lieu of an appeal of the Contractor action.				
The Contractor shall ensure that punitive or retaliatory action is not taken against a Member or service provider that files a grievance or an appeal, or a provider that supports a Member's grievance or appeal.		Substantial	Addressed in P/P KY.QI.11, Member Handbook and Provider Manual. The Work Process does not address "no retaliation". **Recommendation for KY Spirit** The MCO should revise the Work Process to address this requirement.	**MCO Response:** P/P KY QI.11 addresses retaliation as it relates to the provider. KSHP has corrected the policy to include a statement related to members. The corrected P/P KY.QI.11 is submitted as evidence of compliance. **IPRO Comments:** No change in review determination.
24.1 Grievance Process				
A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.				
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member.		Minimal	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01 and the Member Handbook. Grievance File Review KY Spirit had a limited number of member grievances since the MCO has been classifying complaints as grievances only when not resolved within 24 hours. The MCO did not provide a sample for Member Quality Grievances. At the onsite review, the MCO reported only one quality	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the

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
			issue among the grievances filed in Q4 2012. A total of 10 member grievance files were reviewed. Note that one grievance was discontinued due to member not submitting a request in writing. However, members are not required to submit grievances in writing. For appeals, oral filing must be followed by a written appeal. Date that grievance was received was not clearly documented in the files reviewed – either inconsistent information in the file or unable to be discerned from the file documentation provided. The nature of the grievance was not clearly documented in the files provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to	improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire

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
			resolve an adverse quality finding or deficiency identified by the EQRO.	process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013.

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**
				As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
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.		Minimal	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01 and the Member Handbook. <u>Grievance File Review</u> In the file review, this was not evident due to incomplete documentation – lack of acknowledgement letter in the files or actual date grievance was filed not evident	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing

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
			in the file. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This

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 includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve

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**
				months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
The investigation and final Contractor resolution process		Minimal	Addressed in P/P KY.QI.11, Work Process	**MCO Response:** KSHP recognized the

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**
for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant.			KY.QI.11.01 and the Member Handbook. Grievance File Review Timeliness of case processing was not evident due to incomplete documentation or was completed untimely. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any

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
				issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were

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
				reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of

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**
				acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
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	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01 and the Member Handbook. None of the files reviewed required an extension.	
Upon resolution of the grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B above, unless the resolution of the grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following:		Minimal	Addressed in P/P KY.QI.11 and Work Process KY.QI.11.01. Grievance File Review Files included resolution notices however contents of notices did not consistently address sub-requirements noted below. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified,

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**
			resolve an adverse quality finding or deficiency identified by the EQRO.	the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to

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
				show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013.

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**
				As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
A. All information considered in investigating the grievance;		Minimal	Addressed in P/P KY.QI.11 and Work Process KY.QI.11.01. <u>Grievance File Review</u> In the file review, this was not evident due to incomplete documentation. The files contained minimal documentation of correspondence between the MCO and the	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
			member and letters were often missing from the files. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This

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 includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve

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**
				months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
B. Findings and conclusions based on the investigation;		Minimal	Addressed in P/P KY.QI.11 and Work	**MCO Response:** KSHP recognized the

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
and			Process KY.QI.11.01. Grievance File Review In the file review, this was not evident due to incomplete documentation. Files included evidence of reaching a resolution, however, as noted above, the files included minimal documentation of the investigation taken. As a result, the appropriateness of the resolutions is not discernible. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any

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
				issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were

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
				reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and forappropriate documentation of

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**
				acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
C. The disposition of the grievance.		Minimal	Addressed in P/P KY.QI.11 and Work Process KY.QI.11.01. In the file review, this was not evident due to incomplete documentation. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator

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
				was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case

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
				now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and

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**
				appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
24.2 Appeal Process				
An appeal is a request for review by the Contractor of a Contractor action.				
A. An action for purpose of an appeal is:				
(1) the denial or limited authorization of a requested services, including the type or level of service;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01, Member Handbook and Provider Manual.	
(2) the reduction, suspension, or termination of a previously authorized service;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01, Member Handbook and Provider Manual.	
(3) the denial, in whole or in part, of payment for a service;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01, Member Handbook and Provider Manual.	

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
(4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or		Full	Addressed in P/P KY.QI.11 and Work Process KY.QI.11.01.	
(5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.		Non-Compliance	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** This language has been added to the definition of an action in P/P KY.QI.11. P/P KY.QI.11 is attached for your review. **IPRO Comments:** No change in review determination.
(6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.		Minimal	Not addressed in the policies/procedures provided. Addressed in the Provider Manual. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** This language has been added to the definition of an action in P/P KY.QI.11. P/P KY.QI.11 is attached for your review. **IPRO Comments:** No change in review determination.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
B. The Contractor shall mail a notice of action to the Member or service provider. The notice shall comply with 42 CFR 438.10© regarding language and (d) regarding format and shall contain, but not be limited to, the following:		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01 and Provider Manual. Appeal File Review A total of 5 appeal files were reviewed (2 of the 5 files involved EPSDT services – dental). Files included notices of action.	
(1) the action the Contractor has taken or intends to take;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01 and Provider Manual. Appeal File Review Notices of action included the action taken or to be taken.	
(2) the reasons for the action;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01 and Provider Manual. Appeal File Review The reason for the action was included in the notices of 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	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01, Member Handbook and Provider Manual. Appeal File Review The right to file an appeal was included in the notices of action.	

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
(4) the Member's right to request a state fair hearing and what the process would be;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01, Member Handbook and Provider Manual. Appeal File Review The right to request a state fair hearing was included in the notices of action.	
(5) the procedures for exercising the rights specified;		Full	Addressed in P/P KY.QI.11, Work Process KY.QI.11.01, Member Handbook and Provider Manual. Appeal File Review Notices of action were compliant.	
(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and		Substantial	Addressed in P/P KY.QI.11, Member Handbook and Provider Manual. Not addressed in the Work Process. Appeal File Review Notices of action were compliant. **Recommendation for KY Spirit** KY Spirit should include the conditions and procedures for expedited appeals in its Work Process.	**MCO Response:** P/P KY.QI.11 states: Plan will maintain an expedited review process for Appeals when Plan determines the member requests or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function." It also states: "Expedited appeals requested orally do not require subsequent written request."

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
				The Plan believes that this fully addresses the circumstances under which expedited resolution of an appeal is available and the how to formally request an expedited resolution. The Plan requests this be element be revised to reflect full compliance. **IPRO Comments:** No change in review determination. Policy and work process should be consistent.
(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.		Substantial	Addressed in P/P KY.QI.11, Member Handbook and Provider Manual. Not addressed in the Work Process. Appeal File Review Notices of action were compliant. **Recommendation for KY Spirit** The MCO should update the Work Process to address this requirement.	**MCO Response:** P/P KY.QI.11 has an entire section devoted to continuation of member continuation of benefits that addresses this element. The Plan believes that this requirement is fully addressed in P/PKY.QI.11 and request this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination. Policy and work process should be consistent.
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		Non-Compliance	Not addressed in the documentation provided.	**MCO Response:** This is addressed in P/P KY.UM.05 Timeliness of UM Decisions. Per this P/P "If the determination results in a

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**
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.			**Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	denial, reduction or termination of coverage, the Medical Director or designee notifies the provider orally within two (2) business days following receipt of the request and issues a written or electronic notice of the decision, including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the treating physician, PCP, facility and member within three calendar days of the verbal notification." As our contract with CHFS requires and our internal documents indicate, our requirement is more restrictive than the Federal requirement. Based on this information, KSHP requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
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,		Full	Addressed in P/P KY.QI.11, Member Handbook and Provider Manual.	

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
representative, or estate representative of a deceased Member as parties to the appeal.				
D. The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. The Contractor shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.		Minimal	Addressed in P/P KY.QI.11, Member Handbook and Provider Manual. Appeal File Review Files reviewed were not completed timely or timeliness could not be determined due to lack of a dated appeal request in the file. Use of a reviewer who was not involved previously or not a subordinate to the initial reviewer was not evident due to incomplete documentation in the files. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of

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
				receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured

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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
				location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
				The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
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	Addressed in P/PKY.QI.11 and the Member Handbook.	
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.		Minimal	Addressed in P/P KY.QI.11. Appeal File Review In the file review, this was not evident due to incomplete documentation – lack of a dated appeal request in the file. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and

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
			MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance;

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
				findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
				Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
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		Full	Addressed in Grievance and Appeal System KY.QI.11 and the Member Handbook.	

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**
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.			None of the files reviewed required an extension.	
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.		Non-Compliance	Not addressed in appeal policies/procedures provided. Appeal File Review Appeal files reviewed did not include this information. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** P/P KY.QI.11.has been updated to include the member's right to a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. The P/P KY.QI.11 is attached for your reference. **IPRO Comments:** No change in review determination.
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		Non-Compliance	Not addressed in appeal policies/procedures provided. Appeal File Review Appeal files reviewed did not include this information.	**MCO Response:** P/P KY.QI.11.has been updated to include the member's right 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

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**
shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.			**Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	process. The P/P KY.QI.11 is attached for your reference. **IPRO Comments:** No change in review determination.
J. For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information:		Non-Compliance	P/P KY.QI.11 does not address the contents of the appeal resolution letter. Appeal File Review Timeliness of case processing was not evident due to incomplete documentation including lack of dated appeal request. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** This is addressed in P/P KY.QI.11, The policy states "The notice of resolution shall include: •The title(s) and in the case of a grievance with a clinical component, the license number, state of licensure and specialty or subspecialty certifications of the person performing the review; •A statement of the reviewer's understanding of the member's grievance; •The Plan's decision in clear terms and in sufficient detail for the member to respond further to the Plan's position and if applicable, the contract basis or medical rationale shall be given; •A reference to the evidence or documentation used as the basis for the

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
				decision, if appropriate; •The notice shall explain that the member may be advised or represented by a friend or family member, lay advocate, attorney or other representative as chosen by the member and agreed to by the representative. KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: •A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate

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
				record keeping ofreceipts/acknowledgement/decisions notifications. •A weekly team meeting is held to discuss any issues from the previous week. •Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. •The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. •Monthly excel spreadsheets are used for

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
				tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. •Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. •As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution

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**
				correspondence to members/providers. **IPRO Comments:** No change in review determination.
(1) the results and reasoning behind the appeal resolution; and		Non-Compliance	P/P KY.QI.11 does not address the contents of the appeal resolution letter. Appeal File Review Files included resolution notices however the content of the notices used template language that was not customized to the nature of the individual appeal, language was unclear or was not at an appropriate reading level. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** This is addressed in P/P KY.QI.11, The policy states "The notice of resolution shall include: •The title(s) and in the case of a grievance with a clinical component, the license number, state of licensure and specialty or subspecialty certifications of the person performing the review; •A statement of the reviewer's understanding of the member's grievance; •The Plan's decision in clear terms and in sufficient detail for the member to respond further to the Plan's position and if applicable, the contract basis or medical rationale shall be given; •A reference to the evidence or documentation used as the basis for the decision, if appropriate; •The notice shall explain that the member may be advised or represented by a friend or family member, lay advocate, attorney or other representative as chosen by the member and agreed to by the representative

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
				KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appelas. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: •A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/ decisions notifications. •A weekly team meeting is held to discuss any issues from the previous week.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section	Health Plan's and DMS' Responses and Plan of action
				•Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. •The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite. •Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and

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
				retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. •Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. •As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.

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**
(2) the date it was completed.		Minimal	P/P KY.QI.11 does not address the contents of the appeal resolution letter. Appeal File Review Files included date of resolution and resolution letters were dated. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** This is addressed in P/P KY.QI.11, The policy states "The notice of resolution shall include: •The title(s) and in the case of a grievance with a clinical component, the license number, state of licensure and specialty or subspecialty certifications of the person performing the review; •A statement of the reviewer's understanding of the member's grievance; •The Plan's decision in clear terms and in sufficient detail for the member to respond further to the Plan's position and if applicable, the contract basis or medical rationale shall be given; •A reference to the evidence or documentation used as the basis for the decision, if appropriate; •The notice shall explain that the member may be advised or represented by a friend or family member, lay advocate, attorney or other representative as chosen by the member and agreed to by the representative Based on the documentation contained in P/P KY.QI.11, KSHP request this element be revised to reflect full compliance.

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**
				IPRO Comments: No change in review determination.
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	Addressed in P/P KY.QI.11. Appeal File Review This was evident in the file review.	
(1) the right to request a state fair hearing and how to do so;		Full	Addressed in P/P KY.QI.11. Appeal File Review This was evident in the file review.	
(2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and		Full	Addressed in P/P KY.QI.11. Appeal File Review This was evident in the file review.	
(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.		Full	Addressed in P/P KY.QI.11. Appeal File Review This was evident in the file review.	
L. The Contractor shall continue the Member's benefits if all of the following are met:		Full	Appeal File Review This was evident in the file review.	
(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;		Substantial	Addressed in P/PKY.QI.11. The Provider Manual and Member Handbook state that continuation of benefits/services shall occur only if an	**MCO Response:** The Provider Handbook and Member Handbook will be revised with the correct information during the next printing. **IPRO Comments:** No change in review

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**
			appeal is submitted in writing within 10 days of the denial letter. This is not compliant with the 30 day time frame in contract requirements. **Recommendation for KY Spirit** The MCO should revise the Provider Manual and Member Handbook to comply with the contract requirements related to continuation of benefits.	determination.
(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;		Substantial	Addressed in P/PKY.QI.11. The Provider Manual and Member Handbook state that continuation of benefits/services shall occur only if an appeal is submitted in writing within 10 days of the denial letter. This is not compliant with the 30 day time frame in contract requirements. **Recommendation for KY Spirit** The MCO should revise the Provider Manual and Member Handbook to comply with the contract requirements related to continuation of benefits.	**MCO Response:** The Provider Handbook and Member Handbook will be revised with the correct information during the next printing. **IPRO Comments:** No change in review determination.
(3) the services were ordered by an authorized service provider;		Substantial	Addressed in P/PKY.QI.11. The Provider Manual and Member	**MCO Response:** The Provider Handbook and Member Handbook will be revised with the correct information during the next printing.

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**
			Handbook state that continuation of benefits/services shall occur only if an appeal is submitted in writing within 10 days of the denial letter. This is not compliant with the 30 day time frame in contract requirements. **Recommendation for KY Spirit** The MCO should revise the Provider Manual and Member Handbook to comply with the contract requirements related to continuation of benefits.	**IPRO Comments:** No change in review determination.
(4) the time period covered by the original authorization has not expired; and		Substantial	Addressed in P/PKY.QI.11. The Provider Manual and Member Handbook state that continuation of benefits/services shall occur only if an appeal is submitted in writing within 10 days of the denial letter. This is not compliant with the 30 day time frame in contract requirements. **Recommendation for KY Spirit** The MCO should revise the Provider Manual and Member Handbook to comply with the contract requirements related to continuation of benefits.	**MCO Response:** The Provider Handbook and Member Handbook will be revised with the correct information during the next printing. **IPRO Comments:** No change in review determination.
(5) the Member requests extension of the benefits.		Substantial	Addressed in P/PKY.QI.11.	**MCO Response:** The Provider Handbook and

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
			The Provider Manual and Member Handbook state that continuation of benefits/services shall occur only if an appeal is submitted in writing within 10 days of the denial letter. This is not compliant with the 30 day time frame in contract requirements. **Recommendation for KY Spirit** The MCO should revise the Provider Manual and Member Handbook to comply with the contract requirements related to continuation of benefits.	Member Handbook will be revised with the correct information during the next printing. **IPRO Comments:** No change in review determination.
M. The Contractor shall provide benefits until one of the following occurs:				
(1) The Member withdraws the appeal;		Full	Addressed in P/P KY.QI.11.	
(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	Addressed in P/P KY.QI.11	
(3) The Cabinet issues a state fair hearing decision adverse to the Member;		Full	Addressed in P/P KY.QI.11	
(4) The time period or service limits of a previously authorized service has expired.		Full	Addressed in P/P KY.QI.11	

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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**
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	Addressed in P/P KY.QI.11 and the Member Handbook.	
O. If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services.		Full	Addressed in P/P KY.QI.11.	
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	Addressed in P/P KY.QI.11.	
(1) a request from the Member;		Full	Addressed in P/P KY.QI.11.	

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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
(2) a provider's support of the Member's request;		Full	Addressed in P/P KY.QI.11.	
(3) a provider's request on behalf of the Member; or		Full	Addressed in P/P KY.QI.11.	
(4) the Contractor's independent determination.		Full	Addressed in P/P KY.QI.11.	
The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.		Full	Addressed in 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	Addressed in P/P KY.QI.11. Also addressed in the Provider Manual and 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	Addressed in P/P KY.QI.11.	
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	Addressed in P/P KY.QI.11.	
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		Full	Addressed in P/P KY.QI.11.	

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of action**
Member or service provider on behalf of the Member.				
G. The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.		Non-Compliance	Not addressed in the documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KY.QI.11.has been revised with the required information. This policy is attached for your review. **IPRO Comments:** No change in review determination.
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	Addressed in P/P KY.QI.11.	
(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	Addressed in P/P KY.QI.11.	
I. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.		Full	Addressed in P/P KY.QI.11.	
24.4 State Hearings for Members				

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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**
A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, within thirty (30) days of receiving notice of the Action or within thirty (30) days of the final decision by the Contractor.		Full	Addressed in P/P KY.QI.11.	
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.		Substantial	Submission of documentation by the MCO is addressed in the P/P KY.QI.11 however the P/P does not include the 5 day timeframe. **Recommendation for KY Spirit** P/P should be amended to include the timeframe.	**MCO Response:** P/P QI.KY.11.02 has been revised to reflect the contractual requirement. **IPRO Comments:** No change in review determination.
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.		Non-Compliance	Not addressed in the documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** P/P QI.KY.11.02 has been revised to reflect the contractual requirement. **IPRO Comments:** No change in review determination.
27.8 Provider Grievances and Appeals				

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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**
The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the Contractor. Provider grievances or appeals shall be resolved within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the provider. If the Provider requests the extension, the extension shall be approved by the Contractor. A Provider may not file a grievance or an appeal on behalf of a Member without written designation by the Member as the Member's representative. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues.		Minimal	Addressed in P/P KY.QI/11 and the Provider Manual. The Work Process does not address provider grievances and appeals, except with regard to member appeals filed by the provider. <u>Provider Grievance File Review</u> Provider Grievances could not be reviewed. The MCO submitted a sample of member grievances about providers, rather than complaints made by providers. <u>Provider Administrative Appeal File Review</u> 5 files were reviewed: ▪ Timeliness - no documentation of filing was found, so timeliness could not be determined. ▪ Acknowledgement within 5 days – no acknowledgement letters were found in the files. ▪ Nature of appeal was present, but in one case, the information in the letter was not correct – the file showed the appeal was related to OB services and the letter referred to chiropractic. ▪ Date appeal received could not be determined since documentation of filing was not found.	**MCO Response:** P/P Ky.QI.11 addresses Provider Appeals/Grievances. KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/

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**
			▪ Correspondence between MCO and provider was not complete as documentation of the filing was not present, nor was the original denial documentation. ▪ Date of resolution – present. ▪ Resolution – present. ▪ Notice of resolution – present. ▪ Expedited appeals – not applicable. ▪ Opportunity to examine case file – was not noted. ▪ Extension – not applicable. ▪ Resolution notice - present. <u>Provider Medical Necessity Appeal File Review</u> 5 Files were reviewed: ▪ Timeliness – all files were timely. ▪ Acknowledgement within 5 days – acknowledgement letters were not present in 2 files. ▪ Reviewer not involved in previous level of review sometimes could not be determined due to lack of documentation from the original denial. ▪ Appropriate clinical expertise was evident. ▪ Nature of appeal was present.	decisions notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite.

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**
			▪ Date appeal received was not always evident as there was no documentation of filing of appeal. ▪ Correspondence between MCO and provider was not complete as documentation of the filing was not present, nor was the original denial documentation. ▪ Date of resolution was present ▪ Resolution was present, but sometimes was not clear – some upheld letters stated "You may be able to get similar services or supplies, these may include: similar benefits, services, or supplies. ▪ Notice of resolution was present. ▪ Expedited appeals – there was one expedited appeal and evidence of attempt to provide oral notice was not found nor was evidence that the member was advised of limited time to present evidence. ▪ Opportunity to examine case file – was not noted. ▪ Extension – not applicable. ▪ Resolution notice - present. **<u>Corrective Action Plan</u>** In accordance with the DMS/MCO contract	Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for

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**
			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
27. 9 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.		Full	Addressed in subcontractor contracts and the Provider Manual.	
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	Confidentiality is addressed in the UM Program Description and P/P KY.QI.11. Accessibility of records to the Department or its designee and record retention were not addressed. **<u>Corrective Action Plan</u>** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or	**MCO Response:** P/P QI.KY.11.has been revised to reflect the contractual requirement. **IPRO Comments:** No change in review determination.

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**
			deficiency identified by the EQRO.	
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.		Non-Compliance	Based on the results of the file review for grievances and appeals, the requirements for file organization and content were not met. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP recognized the deficiencies in accuracy and record keeping for grievances and appeals in November of 2012. The Supervisor of Grievance and Appeals reviewed all current processes for grievances/appeals and discovered deficiencies existed in the process. Following this review, the Supervisor began developing and implementing a corrective action plan to improve deficiencies noted in processing and tracking of grievances and appeals. During the month of December 2012, the improvements were processed and paralleled with the current system to test the outcomes. Once processes were analyzed and modified, the appeals and grievance department began implementing the adjustments and changes on January 1, 2013. These improvements consisted of the following actions: A third Appeals and Grievance Coordinator was added to ensure adequate resources were available for timeliness and appropriate record keeping of receipts/acknowledgement/decisions

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
				notifications. A weekly team meeting is held to discuss any issues from the previous week. Grievance and Appeal Coordinators are required to use a template for documentation related to data entry of a grievance or appeal into Kentucky Spirit's medical management software program called TruCare. This documentation includes all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. This same type of record was created for appeals. This complete process of documentation allows the member record to show the entire process from receipt to resolution by attaching all related documents to the electronic TruCare case. The grievance/appeal tracking sheet was updated and is utilized for investigations per the coordinators and then scanned and attached to the member's case. Each case now incorporates an electronic copy and a hard copy of the member's documents that are put in a labeled file and kept in a secured location onsite.

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
				Monthly excel spreadsheets are used for tracking grievances and appeals. These were reconfigured and updated to show processing information that is used for monthly and quarterly reporting. The spreadsheets are a more "user friendly" tool for inputting and retrieving information for the appeals and grievance staff. The spreadsheets now contain consistent data across all twelve months. Member and provider correspondence was reviewed for process improvement and the identified improvements were implemented in January 2013. As a safeguard to ensure that all appropriate documentation is included in each grievance or appeal requests and that time lines are in compliance with statutory and contract requirements, the Appeals and Grievance Supervisor reviews/audits the grievance and appeals tracking spreadsheets, the appeals and grievances queues, RightFax, and appeals/grievance mailboxes on a daily basis for compliance. The above process improvements allow for

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**
				accurate maintaining and managing of grievance and appeals records, and for appropriate documentation of acknowledgement and resolution correspondence to members/providers. **IPRO Comments:** No change in review determination.
Documentation regarding the grievance shall be made available to the Member, if requested.		Non-Compliance	Not addressed in the documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** This has been added to P/P KY.QI.11. P/P KY.QI.11 is attached for review. **IPRO Comments:** No change in review determination.

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Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	43	11	18	10
Total Points	129	22	18	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		**169/82=2.06**		

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

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data
Process for quality oversight of grievance processing
Evidence of quality oversight and follow-up for grievance processing

Reports

Quarterly reports of grievances and appeals

File Review

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

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

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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	P/P KY.CM.01.01 states that the plan has programs and processes in place to address assessment of special needs of new members with ongoing monitoring which assess, monitor and evaluate services. P/P CC.CM.6 addresses identification of members for disease and case management services. P/P KY.CM.14.01 explains the process for identification and effective management of individuals with special health care needs, including chronic behavioral, mental or physical conditions. P/P KY.CM.01 describes complex case management. The Member Handbook provides information on case and disease management programs available to members.	
The Contractor shall conduct initial health screening assessment of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.		Minimal	P/P KY.CM.01.01 states that the plan will outreach to all new members within thirty (30) days of eligibility. Regarding pregnant members, the policy reads that members who indicate they are pregnant will be referred to the Start Smart for Your Baby program through completion of the Notification of Pregnancy (NOP) form, and that pregnant members identified as at risk for pregnancy complications will be referred to a High Risk Pregnancy Case Manager. There is no specific documentation in this policy addressing contract stated	**MCO Response:** Policy and procedure KY.CM.01.01 – Health Risk Screening has been revised to include specific contract language, including timeframes. "The Plan 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 who the Plan have reasonable belief to be

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**
			timeframes. HRA File Review Record review indicates that only 7/50 had completed HRAs. Review of follow-up calls indicated that 21 members had no follow-up calls. Most calls were made on one day (11/24/12). Quarterly reports indicate that completion rates are low at less than 30%. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care. The welcome call campaign is a corporate initiative for Centene health plans, including Kentucky Spirit. The Plan's initial welcome campaign activity will be conducted according to the following work process: *Members are mailed a new member packet within the first week of enrollment. * Within 30 days of enrollment, live outreach is attempted. * 60 days after enrollment, a postcard is mailed to the member's address of record. * 75 days after enrollment the member is added to the auto dialer system that performs telephonic outreach. For members believed to be pregnant: * New member packet is mailed within the first week of enrollment. * Live outreach begins within the first week of enrollment. *10 days after enrollment, a postcard is mailed to the member's home address of record. * 14 days after enrollment the member is added to the auto dialer system for telephonic outreach.

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
				*20-25 days after enrollment live outreach performed again if necessary. Due to impending plan closure, the mail response unit at Corporate has discontinued mailing postcards as part of the welcome campaign. Based on closure details, Plan will reinstate mailing activity as part of the welcome campaign. An important factor to note is that the Plan's member population can be extremely difficult to contact. The low completion percentage of initial health screenings can be directly related to an inability to contact the members. **IPRO Comments:** No change in review determination.
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire.		Minimal	P/P KY.CM.01.01 states that the plan will make all reasonable efforts to contact new members by telephone, by mail or in person to have members complete the initial health screening questionnaire. <u>HRA File Review</u> The plan mails out the Welcome Packet with HRA form for each member as a first attempt, which the Plan indicates does not have a good return rate. The policy indicates Welcome Calls are done to complete HRAs.	**MCO Response:** The welcome call campaign is a corporate initiative for Centene health plans, including Kentucky Spirit. The Plan's initial welcome campaign activity will be conducted according to the following work process: *Members are mailed a new member packet within the first week of enrollment. * Within 30 days of enrollment, live outreach is attempted. * 60 days after enrollment, a postcard is

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The number completed as previously indicated was 7/50 so completion rates are low. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	mailed to the member's address of record. * 75 days after enrollment the member is added to the auto dialer system that performs telephonic outreach. For members believed to be pregnant: * New member packet is mailed within the first week of enrollment. * Live outreach begins within the first week of enrollment. *10 days after enrollment, a postcard is mailed to the member's home address of record. * 14 days after enrollment the member is added to the auto dialer system for telephonic outreach. *20-25 days after enrollment live outreach performed again if necessary. Due to impending plan closure, the mail response unit at Corporate has discontinued mailing postcards as part of the welcome campaign. Pending closure details, Plan will reinstate mailing activity as part of the welcome campaign if appropriate. An important factor to note is that the Plan's member population can be extremely difficult to contact. The low completion percentage of initial health screenings can be directly related to an

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**
				inability to contact the members. **IPRO Comments:** No change in review determination.
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.		Full	P/P KY.CM.01.01 states that Information collected includes demographic information and 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. HRA File Review Those HRAs completed fulfilled the requirements.	
The Contractor shall use appropriate healthcare professionals in the assessment process.		Substantial	P/P KY.CM.01.01 does not indicate that healthcare professionals are used in the assessment process. The policy refers to a plan designee but does not specify the designee's qualifications. There is mention of a report titled KY307-HRS Assessment Summary that is monitored daily by case management staff to identify the total number of HRAs completed so candidates can be referred for further evaluation. HRA File Review The plan provided additional information upon request regarding the automatic	**MCO Response:** P/P KY.CM.01.01 – Health Risk Screening policy has been updated to include the following specific contract language: Plan will utilize appropriate healthcare professionals to conduct health screening assessments on new members for the purpose of assessing the member's need for any special health care needs. With this addition of language to the policy, the Plan requests that this element be revised to reflect full compliance.

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**
			scoring system that evaluates the member based on the HRA answers. Only those that score greater than 5 are considered for case management. Of the 7 HRAs completed, all but one (a pregnant member) scored 5 or below. Most had significant health risks and should have been evaluated for case management. **Recommendation for Kentucky Spirit** As discussed with the plan, the current scoring system should be re-evaluated as some cases that scored 5 or below should have been evaluated for case management. The evaluation process should include use of appropriate healthcare personnel, and this process should be documented in a policy/procedure.	Information originally provided indicates that the Plan utilizes a scoring system that identifies a score of 6 or greater as a trigger for Case Management referral. The weighted scoring component that drives the screening score is a Corporate owned process, as it is utilized by multiple health plans. Changes cannot be made at the Plan level. Discussions have taken place between Plan Case Management and the Corporate Medical Management team regarding gaps in the scoring and work is underway to revamp this process. **IPRO Comments:** No change in review determination.
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/P KY.CM.01.01 states members are offered assistance as indicated in the State Contract Requirements. HRA File Review 3 of 7 completed HRAs, provided no documentation that the interviewer offered any assistance in arranging an initial visit with their PCP, even when the member indicated no visit in over 3 months, did not know who their PCP was, and/or needed transportation to get to their PCP. Members were referred to Member Services	**MCO Response:** The absence of a PCP or lack of involvement from a PCP is discovered during completion of the initial health risk screening. The question(s) regarding the PCP are not currently weighted heavily enough to trigger a referral if there are no other issues. The weighted scoring component that drives the screening score is a Corporate owned process, as it is utilized by multiple health plans. Changes cannot be made at

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**
			phone number as per the script for the HRA. **Recommendation for Kentucky Spirit** The MCO should ensure that members are offered assistance as per State Contract Requirements if needed.	the Plan level. Discussions have taken place between Plan Case Management and the Corporate Medical Management team regarding gaps in the scoring and work is underway to revamp this process. **IPRO Comments:** No change in review determination.
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	P/P KY.CM.01.01 states this plan and procedure is in place. Kentucky Spirit provided quarterly reports to review. Quarter 3 and Quarter 4 were the same timeframe and most likely represented an error with transmission. All requirements were included in the reports.	

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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	2	2	0
Total Points	9	4	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**15/7=2.14**		

Reviewer Decision:

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

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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

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

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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**
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	Addressed in P/P CC.CRED.01, Credentialing Program Description. 907 KAR 1:672 also referenced in the following policies: CC.CRED.02 (Credentialing Committee), CC.CRED.03 (Primary Source Verification), CC.CRED.04 (Initial Credentialing Process), CC.CRED.05 (Sanction Information), CC.CRED.07 (Recredentialing), CC.CRED.11 (Organizational Providers).	
defining the scope of providers covered,		Full	Addressed in P/P CC.CRED.01.	
the criteria and the primary source verification of information used to meet the criteria,		Full	Addressed in P/P CC.CRED.01 and P/P CC.CRED.03, Credentialing Committee.	
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.03 and CC.CRED.12, Oversight of Delegated Credentialing.	
The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialling of providers.		Full	Addressed in CC.CRED.01 and CC.CRED.03.	
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		Full	All provider types are accounted for between two documents: CC.CRED.01 and CC.CRED.04, Initial Credentialing Policy.	

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
certified practitioners.				
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.		Full	All provider types are accounted for between two documents: CC.CRED.01 and CC.CRED.04, Initial Credentialing Policy.	
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	Addressed in P/P CC.CRED.01 and P/P CC.CRED.03, Primary Source Verification.	
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	Addressed in P/Ps CC.CRED.01 and CC.CRED.03 Primary Source Verification.	
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		Full	Addressed in P/P CC.CRED.03.	

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Department.				
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.04 and CC.CRED.03.	
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	Addressed in P/Ps CC.CRED.01, CC.CRED.04 and CC.CRED.07, Practitioner Recredentialing.	
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 CC.CRED.01 and CC.CRED.02.	
C. A review of the credentialing policies and procedures by the formal body;		Full	Addressed in P/P CC.CRED.02.	
D. A credentialing committee which makes recommendations regarding credentialing;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.02.	
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.02. Report #15, Oversight of Delegated Services contains evidence of monitoring of all	

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			subcontractor functions, including credentialing. Credentialing Committee monthly meeting minutes submitted for review and contained evidence of monitoring for effectiveness.	
F. Written procedures for the termination or suspension of Providers; and		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.02.	
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	Addressed in P/Ps CC.CRED.01 and CC.CRED.02.Addressed by CC.CRED.10, Practitioner Disciplinary Action and Reporting.	
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.03.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.03. 12 practitioner files reviewed and in compliance.	
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.03. 12 practitioner files reviewed and in compliance.	
C. Primary source of graduation from medical school and completion of an appropriate residency, or		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.03.	

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accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not Board Certified.			12 practitioner files reviewed and in compliance.	
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.03. 12 practitioner files reviewed and in compliance.	
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;		Substantial	Addressed in P/Ps CC.CRED.01 and CC.CRED.03. 12 practitioner files reviewed and in compliance. 12 practitioner files were reviewed and all providers were board certified. Language regarding training to serve children with special health care needs in lieu of board certification was not seen. **Recommendation for KY Spirit** P/P should be amended to include this requirement.	**MCO Response:** P&P will be revised to include language to encompass training to serve children with special health care needs in lieu of board certification. **IPRO Comments:** No change in review determination.
F. Previous five (5) years work history;		Full	Addressed in P/P CC.CRED.03. 12 practitioner files reviewed and in compliance.	

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G. Professional liability claims history;		Full	Addressed in P/P CC.CRED.03. 12 practitioner files reviewed and in compliance.	
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	Addressed in P/Ps CC.CRED.01, CC.CRED.04 and CC.CRED.03. 12 practitioner files reviewed and in compliance.	
I. Current, adequate malpractice insurance, as verified through attestation;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
K. Documentation of curtailment or suspension of medical staff privileges;		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.02 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.04 and CC.CRED.05, Sanction Information. 12 practitioner files reviewed and in	

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			compliance.	
M. Documentation of censure by the State or County professional association; and		Full	Addressed in P/P CC.CRED.05. 12 practitioner files reviewed and in compliance.	
N. Most recent information available from the National Practitioner Data Bank.		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.04, CC.CRED.03 and CC.CRED.05. 12 practitioner files reviewed and in compliance.	
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	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
B. Lack of present illegal drug use;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
C. History of loss of license and felony convictions;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	

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D. History of loss or limitation of privileges or disciplinary activity;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	
F. Applicant attests to correctness and completeness of the application		Full	Addressed in P/P CC.CRED.04. 12 practitioner files reviewed and in compliance.	
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	Addressed in P/Ps CC.CRED.01, CC.CRED.03, CC.CRED.04 and CC.CRED.05. 12 practitioner files reviewed and in compliance.	
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.03 and CC.CRED.04. 12 practitioner files reviewed and in compliance.	

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C. Other recognized monitoring organizations appropriate to the practitioner's discipline.		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.03, CC.CRED.04 and CC.CRED.05. 12 practitioner files reviewed and in compliance.	
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	Addressed in CC.CRED.01. 12 practitioner files reviewed, none documented an office visit; all contained extensive survey regarding office attributes. **Recommendation for KY Spirit** Policy intent seems equivalent to the requirement, but the MCO should update policy to include the required clause "as it deems necessary."	**MCO Response:** None
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.		Full	12 practitioner files reviewed and in compliance; all showed structured review against internal and contractual standards.	
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	12 practitioner files reviewed and in compliance; all showed structured review against internal and contractual 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		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All	

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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:			were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
A. A current license to practice;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
C. A valid DEA, if applicable;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	

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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	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
F. A current signed attestation statement by the applicant regarding:		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
1. The ability to perform the essential functions of the position, with or without accommodation;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
2. The lack of current illegal drug use;		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
3. A history of loss, limitation of privileges or any disciplinary action; and		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All	

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			were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
4. Current malpractice insurance.		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.05 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
A. The national practitioner data bank;		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.05 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
B. Medicare and Medicaid;		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.05 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
C. State boards of practice, as applicable; and		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.05 and CC.CRED.07.	

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			12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.		Full	Addressed in P/Ps CC.CRED.01 and CC.CRED.07. 12 practitioner files submitted for review. All were initially credentialed in 2011 or 2012, and were not due for Recredentialing.	
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.		Substantial	P/P CC.CRED.01 states "Kentucky Spirit Health Plan will accept and utilize the KAPER-1/CAQH Credentialing Application to process credentialing for all practitioners that require credentialing." The policy does not state that coversheets will be generated and submitted electronically to the Department's fiscal agent. Credentialing Process Coversheets were seen in all 12 practitioner files reviewed. **Recommendation for KY Spirit** Add language to P/P that coversheets will be generated and submitted electronically to the Department's Fiscal Agent.	**MCO Response:** P&P will be revised to include language that coversheets will be generated and submitted electronically to the Department's Fiscal Agent. **IPRO Comments:** No change in review determination.
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take		Full	Addressed in P/Ps: CC.CRED.01 CC.CRED.02	

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appropriate action.			CC.CRED.09, Ongoing Monitoring of Sanctions and Complaints CC.CRED.10, Practitioner Disciplinary Action and Reporting CC.QI.18, Quality of Care Investigations Credentialing Committee monthly meeting minutes submitted for review and contained evidence of monitoring of quality issues.	
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	Addressed in P/Ps CC.CRED.01, CC.CRED.02 and CC.CRED.11, Organizational Providers.	
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.		Full	Addressed in P/Ps CC.CRED.01, CC.CRED.02 and CC.CRED.11, Organizational Providers.	
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	Addressed in P/Ps CC.CRED.01 and CC.CRED.10.	
The Contractor shall have procedures for reporting to		Full	Addressed in P/Ps CC.CRED.01 and	

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the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.			CC.CRED.10.	
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	Addressed in P/Ps CC.CRED.01 and CC.CRED.10.	
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Types.htm		Full	Addressed in the following P/Ps: CC.CRED.02 CC.CRED.03 CC.CRED.04 CC.CRED.05 CC.CRED.07 CC.CRED.11.	
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 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		Substantial	All provisions addressed by P/P CC.CONT.02 Network Selection and Retention except use of required enrollment form. **Recommendation for KY Spirit** Update policy to include required provision regarding use of Kentucky Medicaid Program enrollment forms.	**MCO Response:** KSHP Credentialing utilizes MCO Enrollment Manual as provided by the Department for Medicaid Services. Copy of manual provided with this response. With this clarification, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.

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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. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such				

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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	Addressed in CC.CRED.01 Credentialing Program Description, Attachment E, Kentucky Spirit Health Plan Unique Credentialing Requirements, 7, P. 25.	
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.		Full	Addressed in CC.CRED.01 Credentialing Program Description, Introduction, P.2. Addressed in CC.CRED.02 Credentialing Committee, Introduction. Addressed by CC.CONT.02 Network Selection and Retention.	
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	Addressed in CC.CRED.01 Credentialing Program Description, X, Committee Decisions, P. 15.	

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			Addressed by CC.CRED.04 Initial Credentialing Process, Procedure, IV, Denial of Initial Credentialing Application.	
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	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Kentucky Spirit refers to and follows KRS 304.17A-270, 907 KAR 1:672, and 907 KAR 17.005. KY.CONT.01 Network Adequacy effective 9/12 specifies "all eligible provider types" which would capture provider types and providers qualified for EHR. Although we do not set EHR recipients apart they are defined as providers to which the plan offers participation agreements. CC.Cred.01 page 3 specifies: "The Plan's network panel is currently open to accept applications from all practitioners or organizations that meet Plan's minimum criteria as established in the Corporate Credentialing Program. In addition, the Corporate Credentialing Department has established protocols to monitor and prevent discriminatory practices. The participants of the Credentialing Committee sign a non-discrimination form and the Credentialing Committee discusses applicable Corporate and Plan specific policy and standards."

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				With this clarification, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
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.		Non-Compliance	Emergency services provided by providers not in the AMISYS system are included in P/P CC.CONT.03 Single Case Agreement. Departmental enrollment processes to assign provider numbers are not found. Processes for reporting out-of-network utilization to the Department not found. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP has MCO Enrollment Manual provided by the Department for Medicaid Services which provides the requirements. 3rd Comment: Report #81 provided to Department reporting out of network utilization. It is listed as a required report. Copies of reports for 2012 found. No report for Nov & Dec 11. MCO Reports Description doc provides the process/layout of information to report to Department. P&P will be created to address these required actions. **IPRO Comments:** No change in review determination.
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid		Full	Addressed in P/P CC.CRED.04, Initial Credentialing Process.	

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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**
Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.				
28.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry		Full	Addressed in P/P CC.CRED.04.	

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**
access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.				
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.		Non-Compliance	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** CC.CRED.01 Pgs. 7&8 contain the following: The application form must be complete, signed and dated by the applicant and must include attestations for correctness and completeness of the application. The application must include a statement regarding: •Eligibility to become a Medicaid or Medicare provider (if applicable). This would address that we contract/initiate credentialing w/o a Medicaid number. This falls in line with the remaining state contract requirements for this section which were

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**
				omitted: "Provider file records transmitted without a provider number will be suspended until verification of the provider's Medicaid enrollment status and for the assignment of the provider number. When eligibility is confirmed, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contract will receive a report within two weeks of transactions being accepted, suspended or denied. P&P will be updated expand on this process. **IPRO Comments:** No change in review determination.
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 shall be terminated from participation.		Full	Addressed in P/P CC.CRED.09, Ongoing Monitoring of Sanctions and Complaints.	
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Department will notify the Contractor of voluntary terminations within five business days via email.		NA	DMS responsibility.	

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The 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.		Substantial	Addressed in P/P CC.CRED.01 and P/P CC.CRED.10 except the time frames for notifying the Department was not included. **Recommendation for KY Spirit** Update policies and procedures to specify reporting to the Department within the required timeframes.	**MCO Response:** KY.PRVR.05 Provider Termination Policy contains information for reporting terminations as specified in 28.6 and also as specified in 37.10 of the contract. Policy document is provided with this response and was in effect during audit time period. The Plan request this element be revised to reflect full compliance based on the above rationale. **IPRO Comments:** No change in review determination. This policy was not submitted as evidence in the original submission.

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	73	4	0	3
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		**227/80=2.84**		

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; for reviewer information purposes

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing
Suggested Evidence

Documents

Policies and Procedures for:

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

Credentialing Committee description, membership, meeting agendas and minutes

Reports

Reports of oversight of delegated credentialing
Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination
Sample provider file report of provider credentialing for DMS Fiscal Agent
Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

File Review

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

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

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.		Full	Addressed in P/P KY.PRVR.04, PCP Responsibilities.	
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.		Substantial	P/P KY.PRVR.04, PCP Responsibilities states: "Specialists who are willing to provide medical homes to selected members with special needs and conditions will be allowed by Kentucky Spirit Health Plan to act as PCP if they have chosen to practice as a PCP in their credentialing application and is approved by Kentucky Spirit's Medical Director." **Recommendation for KY Spirit**	**MCO Response:** Policy will be revised to address agreement among the member or family and the specialist, and the member's right to appeal. **IPRO Comments:** No change in review determination.

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Policy should be revised to address agreement among the member or family and the specialist, and the member's right to appeal.	
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;		Full	Addressed in P/P KY.PRVR.04.	
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	Addressed in P/P KY.PRVR.04.	
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;		Full	Addressed in P/P KY.PRVR.04.	
D. Discussing Advance Medical Directives with all Members as appropriate;		Full	Addressed in P/P KY.PRVR.04.	
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	Addressed in P/P KY.PRVR.04.	
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and		Full	Addressed in P/P KY.PRVR.04.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers		Full	Addressed in P/P KY.PRVR.04.	
Maintaining formalized relationships with other PCPs to		Full	Addressed in P/P KY.PRVR.04.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.				
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
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	Addressed in P/P KY.PRVR.04.	
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and		Full	Addressed in P/P KY.PRVR.04.	
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.		Full	Addressed in P/P KY.PRVR.04.	
B. Unacceptable				
(1) Office phone is only answered during office hours;		Full	Addressed in P/P KY.PRVR.04.	
(2) Office phone is answered after hours by a recording		Full	Addressed in P/P KY.PRVR.04.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
that tells Members to leave a message;				
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and		Full	Addressed in P/P KY.PRVR.04.	
(4) Returning after-hours calls outside of thirty (30) minutes.		Full	Addressed in P/P KY.PRVR.04.	
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/P KY.UM.01.01, Covered Benefits and Services states: "Medically necessary services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope to reasonably achieve its purpose for the same services furnished to recipients under Fee-for-Service Medicaid. The amount, duration, or scope of coverage will not be arbitrarily denied or reduced solely because of the diagnosis, scope of illness, or condition." **Recommendation for KY Spirit** Policy should be revised to include all elements required, i.e., incentives.	**MCO Response:** Policy will be revised to include all elements required, i.e., incentives. **IPRO Comments:** No change in review determination.
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.		Full	Addressed in P/P KY.UM.01.01.	
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		Full	Addressed in P/P KY.UM.12, Emergency Services.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:				
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.		Substantial	P/P KY.PRVR.10, Measuring Provider Accessibility addresses member to PCP ratio but does not specify the accepted ratio. **Recommendation for KY Spirit** Policy should be revised to include the member to PCP (FTE) ratio not to exceed 1500:1 as stated in the state contract requirements.	**MCO Response:** KSHP refers to the State contract in the P&P to address ratios. See below: In addition, Kentucky Spirit Health Plan will conduct Provider to Member Ratio analysis on a regular basis to ensure that its network of Affiliated Providers maintains the targeted ratios following the State contract. The ratio will be reported using the number of affiliated primary care providers by county and dividing it by the number of enrollees in that same county. The results of the analysis will be provided to the Network Development and Contracting Department to be used in their recruitment strategies. Policy document will be revised to include the member to PCP (FTE) ratio not to exceed 1500:1 as stated in the state contract requirements. **IPRO Comments:** No change in review determination.
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		Substantial	P/P KY.PRVR.10 addresses appointment availability. P/P KY.QI.05 addresses behavioral health services not to exceed 14 days post discharge from an acute psychiatric hospital. Documentation provided does not address services not to exceed 60 days for other or requirement that specialists shall be	**MCO Response:** P&P will be revised to include all requirements. **IPRO Comments:** No change in review determination.

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.			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. **Recommendation for KY Spirit** Policies/procedures should address all requirements.	
C. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.		Full	Addressed in P/P KY.UM.12.	
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.		Substantial	Hospital care addressed in P/P KY.PRVR.10. Behavioral Health and physical rehabilitative services where access shall not exceed 60 minutes is not documented. **Recommendation for KY Spirit** Policy should address all requirements.	**MCO Response:** P&P will be revised to include all requirements. **IPRO Comments:** No change in review determination.
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	P/P KY.PRVR.10 addresses this requirement.	
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		Full	P/P KY.PRVR.10 addresses this requirement.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.				
G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.		Full	P/P KY.PRVR.10 does not address transportation services for pharmacy services. **Recommendation for KY Spirit** Policy should also state that MCO is not required to provide transportation to pharmacy services.	**MCO Response:** KSHP Member Handbook provided and includes policy for: Non-Emergency Transportation Services Kentucky Medicaid will pay to take some members to get medical services covered by Medicaid. Transportation is not covered to pick up prescriptions. If you need a ride, you must talk to the transportation broker in your county to schedule a trip. You must call 72 hours in advance to schedule a ride. Please call 1-888-941-7433 to find out which broker to call to set up a ride. For a list of transportation brokers and their contact information, please visit http://chfs.ky.gov/dms/trans.htm. This list is also available at www.kentuckyspirithealth.com. With this clarification, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** Review determination changed to Full. Member Handbook addresses this requirement.
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;		Full	P/P KY.CONT.01 addresses this requirement.	
B. FQHCs and rural health clinics;		Full	P/P KY.CONT.01 includes FQHCs and rural	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			health clinics.	
C. The Kentucky Commission for Children with Special Health Care Needs; and		Non-Compliance	Not included in policies and procedures. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KY.CONT.01 states: Kentucky Spirit Health Plan will strive to include and or encourage its subcontracted network to include the widest variety of provider types for the benefit of its members. These include but are not limited to: P&P will be revised to specifically include this requirement. **IPRO Comments:** No change in review determination.
D. Community Mental Health Centers		Full	P/P KY.CONT.01 includes Community Mental Health Centers.	
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.		Non-Compliance	P/P KY CONT.01 does not include this requirement. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** The P&P states: The results of the reports and surveys described above will be used collectively by the Network Management and Contracting Department to assess the need for additional provider recruitment and by the Provider Relations Department to identify providers who may need education and/or corrective action plans to bring them into compliance with the health plan's accessibility standards. If at any time, Kentucky Spirit Health Plan determines that its network is not adequate to comply with access standards, Kentucky Spirit Health Plan shall notify the State of Kentucky of the situation and submit a corrective action plan to

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				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 Kentucky Spirit Health plan and timeframes to correct the deficiency. In addition to expanding the service delivery network to remedy access problems, Kentucky Spirit Health Plan shall 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, Kentucky Spirit Health Plan shall contact provider to determine an interest in enrolling and willingness to meet terms and conditions. The results of the reports will also be shared with the State of Kentucky as well as with the health plan's senior management team and other regulatory bodies internal and external to the health plan as may be required and appropriate. P&P will be revised to reflect the recommendations included in this document. **IPRO Comments:** No change in review determination.
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following				

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.		Full	Addressed in P/P KY.CONT.01.	
B. Provide reimbursement at rates commensurate with those provided under Medicare.		Full	Addressed in P/P KY.CONT.01.	
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.		Non-Compliance	This requirement is not addressed in the policies provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KY.CONT.01 states: Kentucky Spirit Health Plan will strive to include and or encourage its subcontracted network to include the widest variety of provider types for the benefit of its members. These include but are not limited to: P&P will be revised to include exact wording from contract. **IPRO Comments:** No change in review determination.
The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to 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.		Substantial	P/P CC.QI.04, Evaluation of Practitioner Availability addressed this requirement however it does not include provision to submit documentation to the Department if the MCO is unable to contract with sufficient types, numbers and specialties of providers. **Recommendation for KY Spirit** This requirement should be addressed in a policy/procedure.	**MCO Response:** KY.CONT.01 provided. The P&P states: The results of the reports and surveys described above will be used collectively by the Network Management and Contracting Department to assess the need for additional provider recruitment and by the Provider Relations Department to identify providers who may need education and/or corrective action plans to bring them into compliance with the health plan's accessibility standards. If at any time, Kentucky Spirit Health Plan determines that its network is not adequate to

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				comply with access standards, Kentucky Spirit Health Plan shall notify the State of Kentucky of the 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 Kentucky Spirit Health plan and timeframes to correct the deficiency. In addition to expanding the service delivery network to remedy access problems, Kentucky Spirit Health Plan shall 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, Kentucky Spirit Health Plan shall contact provider to determine an interest in enrolling and willingness to meet terms and conditions. The results of the reports will also be shared with the State of Kentucky as well as with the health plan's senior management team and other regulatory bodies internal and external to the health plan as may be required and appropriate. P&P will be revised to reflect the contractual requirements. **IPRO Comments:** No change in review determination.
28.8 Program Mapping				
The Contractor shall initially submit a series of maps and charts in a format prescribed by the Department that		Full	P/P CC.QI.04, Evaluation of Practitioner Availability states the Contractor will use	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.			computer-generated maps (GeoAccess) to assess availability of PCPs. Geo Access maps and analysis were provided.	
Maps shall include the location of all categories of Providers or provider sites as follows:				
A. Primary Care Providers (designated by a "P")		Full	There are multiple geographical maps that are designated solely for providers and show the numbers of available PCPs with 30 and 60 mile radius illustrated. An accessibility analysis dated 12/7/12 reports 100% access.	
B. Primary Care Centers, non FQHC and RHC (designated by a "C")		Non-Compliance	This category was not addressed in maps provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP will initiate programming changes to identify PCCs per the contractual requirement. **IPRO Comments:** No change in review determination.
C. Dentists (designated by a "D")		Substantial	Accessibility summary reviewed. A map with dentists was not seen. There is a summary of dentists dated 12/7/12 indicating KY access at	**MCO Response:** KSHP will initiate programming changes to identify dentists per the contractual requirement.

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			57.8%. Region 4 at 69%, Region 8 at 10.9%, Region 6 at 46.9% and Region 7 at 62%. Summary dated in January 2013 shows 100% access for all regions. **Recommendation for KY Spirit** The MCO should produce maps for all required categories.	**IPRO Comments:** No change in review determination.
D. Other Specialty Providers (designated by a "S")		Full	There were Specialty Providers with their own maps such as a Pulmonologist map of KY, Orthopedist map etc. Specialty provider analysis reports showed adequate access.	
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	Midwives and Nurse Practitioners are located on their own maps. Physician Assistants were not identified. **Recommendation for KY Spirit** The MCO should produce maps/analysis for all required categories.	**MCO Response:** KSHP will initiate programming changes to identify Physician Assistants. **IPRO Comments:** No change in review determination.
F. Hospitals (designated by a "H")		Full	An accessibility analysis dated 12/7/12 reports 100% access.	
G. After hours Urgent Care Centers (designated by a "U")		Non-Compliance	No accessibility analysis available for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to	**MCO Response:** KSHP will initiate programming changes to identify After hours Urgent Care centers. CAP will be provided in the timeframe identified in this document. **IPRO Comments:** No change in review determination.

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			take to resolve an adverse quality finding or deficiency identified by the EQRO.	
H. Local health departments (designated by a "L")		Non-Compliance	No accessibility analysis available for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP will initiate programming changes to identify local health departments. CAP will be provided in the timeframe identified in this document. **IPRO Comments:** No change in review determination.
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)		Full	FQHCs and Rural Health Centers had their own maps identifying providers that were available at these locations. An accessibility analysis dated 12/7/12 reports: 90.7% with access and 9.3% without access for RHCs.	
J. Pharmacies (designated by a "X")		Full	Pharmacies were on their own map. An accessibility analysis dated 12/7/12 reports access of 21.6% for KY. With the exception of Region 6, all regions showed inadequate access. Analysis report for January 2013 shows 100% access for all regions.	
K. Family Planning Clinics (designated by an "Z")		Non-Compliance	No accessibility analysis available for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action	**MCO Response:** KSHP will initiate programming changes to identify Family Planning Clinics. CAP will be provided in the timeframe identified in this document. **IPRO Comments:** No change in review

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	determination.
L. Significant traditional Providers (designated by an "*")		Non-Compliance	No accessibility analysis available for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP will initiate programming changes to identify significant traditional Providers. CAP will be provided in the timeframe identified in this document. **IPRO Comments:** No change in review determination.
M. Maternity Care Physicians (designated by a "°")		Full	OB/GYNs are designated on their own map with a 30 and 45 mile radius. An accessibility analysis dated 12/7/12 reports: Urban: 14,250 (100.0%) with access (100.0%), without access (0.0%) Suburban: 5,247 (100.0%) with access (88.2%), without access (11.8%) Rural: 114,052 (100.0%) with access (99.4%), without access (0.6%).	
N. Vision Providers (designated by a "V")		Full	Vision centers Accessibility Analysis dated 12/7/12 reports KY with access at 94.6%. Region 6 showed access at 59.2%. Analysis report for January 2013 shows 100% access for all regions.	
O. Community Mental Health Centers (designated by a		Full	CMHCs are designated on their own map.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
"M")				
The Contractor shall update these maps to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.		Full	Addressed in P/P KY.CONT.01.	
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	Addressed in P/P KY.CONT.01.	
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.		Full	Addressed in P/P KY.CONT.01.	
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		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services and P/P KY.UM.24, Continuity and Coordination of Services.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.				
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to 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	Addressed in P/P KY.UM.24.	
After the Execution Date, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2 and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written		NA	DMS Responsibility.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.		Non-Compliance	Not addressed in the documents provided for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** The requirement specifies the Contractor may provide. All member related activities are subject to review and approval by the Department as covered by CC.COMM.19 – Communication Material Review and Approval. **IPRO Comments:** No change in review determination.
If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.		Minimal	P/P KY.PRVR.04, PCP Responsibilities states: Documenting all care rendered in a complete and accurate medical record that meets or exceeds specifications as established by the Cabinet for Health and Family Services. This P/P does not address the completion of required forms, retention of these forms, and provision of forms to DMS upon request. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action	**MCO Response:** KY.UM.33 - Prior authorization and coverage of abortion, sterilization and hysterectomy provided to verify required completion. This information is also included in Provider Manual pg. 14. With this clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	determination. Provider Manual only addresses how to access forms, not retention or provision of a copy during audit.
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.		Substantial	P/P KY.PRVR.04, PCP Responsibilities states: "Kentucky Spirit Health Plan requires its PCP to serve as a member's initial and most important point of contact with the MCO and to abide by the responsibilities described in Kentucky Spirit Health Plan Provider Office Manual." Provider Manual Pages 57- 59 describes providers' rights and responsibilities; does not address restriction of provider actions. **Recommendation for KY Spirit** MCO policy should address this MCO requirement.	**MCO Response:** P&P will be updated to address restriction of provider actions. **IPRO Comments:** No change in review determination.
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.		Substantial	P/PKY.UM.24 and P/P KY.CONT.01 do not address requirements regarding payment, cost to member and need to provide services until the MCO is able to cover the services in network. **Recommendation for KY Spirit** Policies should be revised to address requirements regarding payment, cost to member and the need to provide services for as long as Contractor needs to due to inability to cover in network.	**MCO Response:** KY.CONT.03-Single Case Agreement covers this requirement. The Plan requests this element be revised to reflect full compliance based on the above clarification. **IPRO Comments:** No change in review determination. Policy not provided in initial submission.

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A 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	Addressed in Member Handbook.	
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).		Full	Addressed in P/P KY.UM.12, Emergency Services.	
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	Addressed in P/P KY.UM.12, Emergency Services.	
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.		Full	Addressed in P/P KY.UM.12, Emergency Services.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.		Full	Addressed in P/P KY.CONT.01.	
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	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
D. Maternity care for Members under 18 years of age;		Full	Addressed in P/P KY.UM.01.01, Covered	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Benefits and Services.	
E. Immunizations to Members under 21 years of age;		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
F. Sexually transmitted disease screening, evaluation and treatment;		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
G. Tuberculosis screening, evaluation and treatment;		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
I. Chiropractic services; and		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
J. Women's health specialists.		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
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	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under		Full	Addressed in P/P KY.UM.01.01, Covered Benefits and Services.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.				

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Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	58	10	1	9
Total Points	174	20	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		**195/78=2.50**		

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; for reviewer information purposes

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Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability
Monitoring of provider compliance with PCP responsibilities
Provider Access and Availability Reports
Provider program capacity/program mapping reports including geo access, in required format for:

- Primary care
- Specialty care
- Emergency care

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

Evidence of evaluation, analysis and follow-up related to provider program capacity reports
Reports of Out-of-Network Utilization
Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring

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

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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**
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	Addressed in the 2012-2013 UM Program Description. Program components contributing to ongoing monitoring and evaluation of the appropriateness of care are described throughout the document.	
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	Addressed in the 2012-2013 UM Program Description. Monitoring and evaluation of delegated activities is also described in P/P KY.UM.02, Clinical Decision Criteria and Application, Section IV. Oversight of Delegated Activities.	
The description shall include the scope of the program;		Full	Addressed in the 2012-2013 UM Program Description.	
the processes and information sources used to determine service coverage;		Full	Addressed in the 2012-2013 UM Program Description.	
clinical necessity, appropriateness and effectiveness;		Full	Addressed in the 2012-2013 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;		Substantial	The 2012-2013 UM Program Description, P. 26. states "The UM Program will be evaluated at least annually and modifications made as necessary. " "The evaluation covers all aspects of the UM Program." Language does not address specific requirements. **Recommendation for KY Spirit** Program Description should be updated to specify required elements.	**MCO Response:** The UM Program Description has been updated to include specific requirements. "The evaluation covers all aspects of the UM Program including care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery." UM Program Description attached.

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				With submission of document amendment, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
processes to review, approve, and deny services as needed.		Full	Addressed in the 2012-2013 UM Program Description.	
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.		Full	Addressed in the 2012-2013 UM Program Description. KY Spirit reported that the UM Program Evaluation was not completed for 2011 as the health plan started operations 11/1/11. The first annual evaluation (for 2012) will be conducted in 2013.	
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	Addressed in 2012-2013 UM Program Description.	
The Contractor shall adopt national recognized standards and criteria which shall be approved by the Department.		Substantial	Addressed in 2012-2013 UM Program Description and P/P KY.UM.02, Clinical Decision Criteria and Application; however requirement of DMS approval not included. **Recommendation for KY Spirit** Policies should note that DMS approval is required.	**MCO Response:** Language has been added to the UM Program Description and Policy KY.UM.02 Clinical Decision Criteria and Application to state that criteria is subject to approval by the Department of Medicaid Services (DMS). Program Description and policy are attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance.

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**
				IPRO Comments: No change in review determination.
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.		Full	Addressed in 2012-2013 UM Program Description. QI/UM minutes submitted as evidence of evidence of provider involvement in the review process and adoption of medical necessity criteria.	
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.		Full	Addressed in 2012-2013 UM Program Description and P/P KY.UM.02. The 2011/2012 IRR individual testing results and summary were included with submitted documents, with scores ranging from 76% to 100%. Improved scores on test retake (for scores <90%) were noted.	
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	Addressed in 2012-2013 UM Program Description and P/P KY.UM.02.01, Medical Necessity Review. <u>UM File Review</u> 20 member records with UM Denials submitted for review: 15 records contained administrative denials and 5 records were denials based on medical necessity. All 5 records contained evidence clinical information was obtained; no records required consultation with the attending physician or other health care provider.	

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 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	Addressed in 2012-2013 UM Program Description and P/P KY.UM 02.01. UM File Review 20 member records with UM Denials submitted for review: 15 records contained administrative denials and 5 records were denials based on medical necessity. All 5 records contained evidence the denial decision was made by a physician with appropriate clinical expertise.	
The reason for the denial shall be cited.		Full	Addressed in 2012-2013 UM Program Description and P/P KY.UM 02.01. UM File Review 20 member records with UM Denials submitted for review: 15 records contained administrative denials and 5 records were denials based on medical necessity. All 5 records contained evidence of member notification including the reasons for the action taken.	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.		Full	Addressed in 2012-2013 UM Program Description and P/P KY.UM 02.01.	
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.		Full	Addressed in 2012-2013 UM Program Description.	
A. The Contractor shall submit its request to change any prior authorization requirement to the		Full	Addressed in P/P KY.UM.01, Utilization Management Program Description.	

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**
Department for review.				
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.		Minimal	The 2012-2013 UM Program Description states "The delegated group is responsible for providing a written UM Program Plan for annual review and approval by Plan's QIC" and "The delegated group must conform to Plan's UM standards; including timeframes outlined in the policy and procedure Timeliness of UM Decisions." Language regarding mechanism to ensure consistent application of review criteria not addressed in the UM Program or in individual executed agreements with subcontractors. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy KY.UM.15 Oversight of Delegated Utilization Management states, "The Plan retains accountability for delegated services and as such will monitor the performance of the delegated entity through the approval of the delegate's UM program (or portions of the program that are delegated), through routine reporting and through annual or more frequent evaluation to determine whether the delegated activities are being carried out according to NCQA, URAC, and/or {Plan standards." Refer to sections IV and V for specifics about annual evaluation and deficiencies and corrective action. Policy attached. With submission of additional documentation, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
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.		Non-Compliance	Evidence of compliance not found. The Program Description, P. 20, Section Denial Notices, states upon adverse determination, a written notification, at a minimum, will be communicated to the member and requesting practitioner. Written confirmation of approvals is not addressed.	**MCO Response:** Policy KY.UM.05 states, "In the event that a member or provider requests written confirmation of an approval, the Plan shall provide this confirmation of its decision within two business days of providing notification of a decision if the initial decision was not in writing." Policy attached. With submission of additional documentation and

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**
			P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (Policy UM.05 is referenced in Policy KY.UM 02.01 Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	this clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
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	Addressed in 2012-2013 UM Program Description and P/P KY.UM.24, Continuity and Coordination of Services.	
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.		Full	Addressed in 2012-2013 UM Program Description.	
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	Addressed in 2012-2013 UM Program Description.	
The program shall identify and describe the mechanisms to detect under-utilization as well as		Full	Addressed in 2012-2013 UM Program Description and P/P KY UM 01.03, Monitoring	

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**
over-utilization of services.			Utilization.	
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	Addressed in the 2012-2013 UM Program Description and P/P KY.UM 02.01, Medical Necessity Review (TruCare).	
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.		Full	Addressed in 2012-2013 UM Program Description. 2012 Medicaid CAHPS reports submitted for review. Provider Satisfaction Survey Policy (CC.PRVR.04 Analyzing Provider Survey Results) and undated Provider Survey Final_Comments_Report submitted for review.	
The UM program will be evaluated by DMS on an annual basis.		Full	Addressed in 2012-2013 UM Program Description.	
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	Addressed in 2012-2013 UM Program Description.	
(a) The action the Contractor has taken or intends to take;		Full	Addressed in 2012-2013 UM Program Description.	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			UM File Review 20 member records with UM Denials submitted for review: 15 records contained administrative denials and 5 records denials based on medical necessity. All 5 records contained evidence member notification included the action the Contractor intended to take.	
(b) The reasons for the action;		Full	Addressed in 2012-2013 UM Program Description. UM File Review 20 member records with UM Denials submitted for review: 15 records contained administrative denials and 5 records denials based on medical necessity. All 5 records contained evidence member notification included the reasons for the action taken.	
(c) The Member's right to appeal;		Full	Addressed in 2012-2013 UM Program Description. UM File Review 20 member records with UM Denials submitted for review: 15 records contained administrative denials and 5 records denials based on medical necessity. All 5 records contained evidence member notification included the member's right to appeal.	
(d) The Member's right to request a State hearing;		Full	Evidence of compliance not found in policies/procedures or the UM Program Description.	**MCO Response:** UM Program Description page 21, Member Handbook page 49, and UM Policy KY.UM.08 Appeal of UM Decisions outline the

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			UM File Review Twenty member records with UM Denials were reviewed: 15 records contained administrative denials and 5 records denials were based on medical necessity. All 5 records contained evidence of member notification including the member's right to request a state hearing. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Member's right to a State Fair Hearing. The Member Handbook provides instructions on the process and under what circumstances this option is available to them. Policy and documentation attached. With submission of additional documentation, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** Review determination changed to Full. Addressed in UM Program Description.
(e) Procedures for exercising Member's rights to appeal or file a grievance;		Full	Addressed in 2012-2013 UM Program Description. UM File Review All 5 records based on medical necessity contained evidence member notification included procedures to file an appeal or grievance.	
(f) Circumstances under which expedited resolution is available and how to request it; and		Substantial	The UM Program Description addresses the availability, process and timeframes for appeal of the decision. Availability of an expedited resolution and how to request an expedited resolution are not addressed. UM File Review	**MCO Response:** Policy KY.UM.08 Appeal of UM Decisions states, "Expedited appeals are available to members for any urgent care requests." Page 48 of the Member Handbook states, "You or your doctor may want us to make a fast decision. You can ask for an Expedited Review if you or your doctor feel that your health is at risk. If you feel this

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**
			All 5 records based on medical necessity contained evidence of member notification including circumstances under which expedited resolution was available and how to request it. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	is needed, call our Grievance and Appeal Coordinator at 1-866-643-3153." Policy and documentation attached. With submission of additional documentation, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** Review determination changed to Substantial. Addressed in Member Handbook. Policy/procedure not provided with original submission.
(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.		Minimal	Evidence of compliance not found in UM Program Description or policies/procedures. UM File Review All 5 records based on medical necessity contained evidence member notification included the right to continued benefits pending resolution of appeal, and the circumstances under which the member may be responsible for the cost of services. **Recommendation for KY Spirit** Update Program Description and policies/procedures to include language regarding continued benefits and member liability.	**MCO Response:** Member Handbook, page 49 states, "You may ask to keep getting care related to your review while we decide. You may have to pay for this care, if the decision is *not* in your favor." Further explanation of how to request this is also included. Language added to the UM Program Description on page 21. Updated UM Program Description and documentation attached. With submission of additional documentation this should be brought to full compliance. **IPRO Comments:** No change in review determination. Addressed in Member Handbook but not in UM Program Description or policy/procedure.
The Contractor must give notice at least: A. Ten (10) days before the date of Action when		Non-Compliance	Evidence of compliance not found.	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to

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 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.			The Program Description, P. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	section E titled, "Advance Notice". Policy attached. With submission of document amendment this should be brought to full compliance. **IPRO Comments:** No change in review determination.
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP

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**
			practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Requirement. **IPRO Comments:** No change in review determination.
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.

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**
			referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
3. The Member's admission to an institution where he is ineligible for further services;		Non-Compliance	Evidence of compliance not found. The Program Description, P. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. Policy UM.05 Timeliness of UM Decisions and Notifications was not submitted (Policy UM.05 is referenced in Policy KY.UM 02.01 Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
4. The Member's address is unknown and mail directed to him has no forwarding address;		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
5. The Member has been accepted for Medicaid services by another local jurisdiction;		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached.

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**
			"Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
6. The Member's physician prescribes the change in the level of medical care;		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review

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State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	determination.
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare).	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.

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State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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.		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, action triggers and notification timelines (beyond non-urgent and urgent decisions) are not included in this document. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted (P/P UM.05 is referenced in P/P KY.UM 02.01, Medical Necessity Review (TruCare). **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or	**MCO Response:** Language added to Policy KY.UM.07 Adverse Action (Denial) Notices. Refer to section E titled, "Advance Notice". Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.

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**
			deficiency identified by the EQRO.	
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.		Non-Compliance	Evidence of compliance not found. The Program Description, p. 18, states "The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within two (2) business days following receipt of the request (Contract Section 20.7), with a possible extension of fourteen (14) calendar days (CFR438.210(d)(1), Contract Section 20.7). A determination for urgent pre-service care (expedited prior authorization) will be issued within two (2) business days (Contract Section 20.7). All preadmission reviews for hospital admissions and any preauthorization for outpatient surgery must be treated as urgent reviews (KRS 304.17A-600(17)(b). The Plan will make determination for urgent concurrent, expedited continued stay and/or post stabilization review within 24 hours of receipt of the request for services. Medical necessity of post service decisions (retrospective review) and subsequent member/ practitioner notification will occur no later than thirty (30) days from receipt of request." No language found stating notice must be made on the date of the Action when the Action is a denial of payment.	**MCO Response:** Policy KY.UM.05 Timeliness of UM Decisions and Notifications states for nonurgent preservice decisions, "If the determination results in a denial, reduction or termination of an urgent pre-service request, the Medical Director or designee will notify the provider orally within two (2) business days of the determination not to exceed the original determination period, and issue a written or electronic notice of the decision including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the treating physician, PCP, facility, and member within three calendar days after the oral notification. For urgent preservice decisions the time frame is one (1) business day. The Plan believes this meets the contractual obligation of notification as all decisions are rendered within one (1) or two (2) business days of receipt of request as dictated by the type of request. For clarification purposes the following has been amended in the policy for both types of requests: "…the Medical Director or designee will notify the provider orally on the day of the determination not to exceed the original determination period…" Policy attached. With submission of document amendment, the

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**
			P/P UM.05, Timeliness of UM Decisions and Notifications was not provided for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.		Minimal	The Program Description, p. 18, states "The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within two (2) business days following receipt of the request (Contract Section 20.7), with a possible extension of fourteen (14) calendar days." Reasons for an extension are not included. P/P UM.05, Timeliness of UM Decisions and Notifications was not submitted. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy KY.UM.05 Timeliness of UM Decisions and Notifications states, "…all time frames are maximum time frames; UM decisions should be made as expeditiously as the member's health condition requires" and "If the Plan is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to a total of 14 calendar days. Within 2 business days of the original request, the member or member's authorized representative is notified of the extension and the expected date the determination will be made. Notification must be in writing and include the reason for the delay and the member's right to file a grievance if they disagree with the extension." Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP

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**
				Requirement. **IPRO Comments:** No change in review determination.
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.		Minimal	The Program Description, p. 18, states "The Plan will make determinations for standard, non-urgent, pre-service prior authorization requests within two (2) business days following receipt of the request (Contract Section 20.7), with a possible extension of fourteen (14) calendar days." Written notification of an extension including the reason for the extension and right to file a grievance are not addressed. P/P UM.05 was not submitted. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy KY.UM.05 Timeliness of UM Decisions and Notifications states, "…all time frames are maximum time frames; UM decisions should be made as expeditiously as the member's health condition requires" and "If the Plan is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to a total of 14 calendar days. Within 2 business days of the original request, the member or member's authorized representative is notified of the extension and the expected date the determination will be made. Notification must be in writing and include the reason for the delay and the member's right to file a grievance if they disagree with the extension." Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's		Minimal	Plan language varies from the requirement, and does not reference Member's health condition (but does address hospitalization).	**MCO Response:** This is addressed in P/P KY.UM.05 Timeliness of UM Decisions states, "If the determination results in a denial, reduction or

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**
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.			The Program Description, p. 18, states "A determination for urgent pre-service care (expedited prior authorization) will be issued within two (2) business days (Contract Section 20.7). All preadmission reviews for hospital admissions and any preauthorization for outpatient surgery must be treated as urgent reviews (KRS 304.17A-600(17)(b). The Plan will make determination for urgent concurrent, expedited continued stay and/or post stabilization review within 24 hours of receipt of the request for services. " **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	termination of coverage, the Medical Director or designee notifies the provider orally within two (2) business days following receipt of the request and issues a written or electronic notice of the decision, including reason, right to a peer-to-peer discussion, right to appeal and the appeal process to the treating physician, PCP, facility and member within three calendar days of the verbal notification." As our internal requirement is more restrictive than the Federal requirement, we believe that this requirement has been met in full. **IPRO Comments:** No change in review determination.
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.		Non-Compliance	Evidence of compliance not found. The Program Description, P. 18, states "Established timelines are in place for practitioners to notify Plan of a service request and for Plan to make UM decisions and subsequent notifications to the member and practitioner;" however, notifications of missed deadlines are not addressed in this document.	**MCO Response:** Policy KY.UM.05 states, "Plan will not deny or reduce payment for a service, procedure, treatment, drug or device covered under the health benefit plan if: During normal business hours, contacts the Plan on the day the member is expected to be discharged, in order to request review of the continued hospitalization, and the a timely utilization review decision is not provided; or The provider makes at least three (3) documented

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**
			P/P UM.05 was not submitted. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	attempts in a four (4) consecutive hour period during normal business hours to contact the Plan for review of a continued hospital stay, preauthorization of treatment for a member or for retrospective review of an emergency hospital admission where the member remains hospitalized at the time the request is made, and the Plan is not accessible. Policy attached. With submission of document amendment, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	29	3	5	12
Total Points	87	6	5	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		**98/49=2.00**		

Reviewer Decision:

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

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

Documents

Policies/procedures for:

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

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

Reports

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

File Review

Sample of UM files selected by EQRO

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

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
36. Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix 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	Addressed in P/Ps KY.COMP.16 – Fraud Abuse and Waste Compliance Plan and CC.COMP.20 – Health Plan Recoupment Policy.	
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;		Minimal	P/P KY.COMP.16 was provided. The Business Ethics and Code of Conduct were not provided. KY.COMP.27 is referenced however the P/P was not provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;		Full	Addressed in P/P KY.COMP.16 and the Organizational Chart.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;		Minimal	Addressed in P/P KY.COMP.16. However, this policy only addresses training for PIU staff and KY Spirit health plan staff. Providers and member training is not addressed. In addition, a copy of the training materials and evidence of staff attendance were not provided. Subcontractor training by the MCO is referenced, but materials or evidence of conducting training was not provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
D. Effective lines of communication between the compliance officer and the organization's employees;		Full	Addressed in P/P KY.COMP.16.	
E. Enforcement of standards through disciplinary guidelines;		Non-Compliance	Not addressed in the documents provided. Provider sanction P/P CC.CRED.05 is referenced, but the P/P was not provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
F. Provision for internal monitoring and auditing of the member and provider;		Substantial	P/P KY.COMP.16 indicates that the following circumstance would not warrant a full investigation; an educational letter is sent: reports of other individuals using the member's ID card. **Recommendation for KY Spirit** The policy should be revised to allow for instances when potential card sharing would warrant a full investigation.	**MCO Response:** None
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;		Full	Addressed in KY.COMP.16.	
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;		Minimal	Addressed in P/P KY.COMP.16. However, no documentation of internal monitoring or audits conducted was provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;		Full	Addressed in KY.COMP.16. In addition, the MCO submitted case listings, case files, and disclosure information for the EQR Annual	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Review.	
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;		Full	Addressed in P/Ps CC.COMP.20 and KY.COMP.16. Monthly reports (SUR 72) of activity and collections were provided for CY 2012.	
K. Contractor shall provide procedures for appeal process;		Full	Addressed in P/P KY.QI.11 – Grievance and Appeal System Description, KY.UM.02.01 – Policy and Procedure for UM - Medical Necessity Review, and KY.QI.11.01 Grievance Work Process.	
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;		Non-Compliance	P/P KY.COMP.16.01, EOB Service Verification is referenced. However, this P/P was not provided nor was documentation that this activity was conducted. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
M. Contractor shall create a process for card sharing cases;		Non-Compliance	Not addressed in the documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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 overpayments collected;		Minimal	MCO provided reports of algorithms for detecting potential FWA cases. Algorithm reports (SUR 75) were provided for each month of 2012 with all fields blank. However Provider FWA Report 76 showed a variety of cases that were identified by the algorithms. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
O. Contractor shall follow cases from the time they are opened until they are closed; and		Non-Compliance	Case file review evidenced cases with only preliminary reports and/or documentation ended before case was designated as closed, and/or there were notations of actions to be taken (e.g., request medical records) but no documentation of the completed actions. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
P. 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.		Non-Compliance	No documentation of attendance at DMS-sponsored FWA trainings was provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
The plan shall be made available to the Department for review and approval.		Full	Fraud, Waste, and Abuse Plan was approved by DMS.	
10.1 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance		Full	Addressed in KY.COMP.16.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.				
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	The organizational chart lists the following positions: Compliance Manager, Compliance Specialist, and Compliance Coordinator (2).	
37.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:		Substantial	See sub-requirements below.	**MCO Response:** None
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		Substantial	2012 Annual Disclosure of Ownership addressing KY Spirit and subcontractors provided.	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;			A total of 9 entities were reviewed and findings are noted below: Cenpatico – 8 officers identified, none listed on excluded lists Magellan – 13 officers identified, none listed on excluded lists National Imaging – 10 officers identified, none listed on excluded lists Nurtur Health – One officer identified, not listed on excluded lists US Script – One officer identified, not listed on excluded lists KY Spirit – One officer identified, not listed on excluded lists MCNA – 6 officers identified, none listed on excluded lists Nurse Wise – 3 officers identified, none listed on excluded lists OptiCare – One officer identified, the entity is listed on the EPLS **Recommendation for KY Spirit** KY Spirit should investigate the accuracy of	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			this finding.	
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	2012 Annual Disclosure of Ownership provided addressing KY Spirit and subcontractors.	
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $250,000 during the immediately preceding twelve-month period;		Full	Addressed in 2012 Annual Disclosure of Ownership.	
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	Addressed in 2012 Annual Disclosure of Ownership.	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;		Full	Addressed in 2012 Annual Disclosure of Ownership.	
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	Addressed in 2012 Annual Disclosure of Ownership.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.		NA	Change in ownership not applicable.	
State Contract, Appendix M				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;		Full	Addressed in P/P KY.COMP.16.	
B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;		Full	Addressed in P/P KY.COMP.16.	
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;		Non-Compliance	No documentation of the number of staff or roles/professional qualifications of the PIU staff for KY Spirit was provided. **Corrective Action Plan**	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
D. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(2) High dollar amount of potential overpayment; or		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;		Non-Compliance	No documentation of training sessions or staff attendance provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
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.		Non-Compliance	No documentation of attendance at DMS-sponsored FWA programs was provided. **Corrective Action Plan**	**MCO Response:** None

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
FUNCTION: The Contractor shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:		Full	Addressed in P/P KY.COMP.16 and demonstrated in FWA case file reviews.	
A. Preventing Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of member and provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.		Full	Addressed in P/P KY.COMP.16.	
B. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;		Full	Addressed in P/P KY.COMP.16. Results of algorithms contained in monthly reports. Monthly member and provider FWA reports (76, 77) were provided.	
C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;		Full	Addressed in P/P KY.COMP.16.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;		Full	Addressed in P/P CC.COMP.20.	
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	Addressed in P/P KY.COMP.16.	
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;		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
G. Making and receiving recommendations to enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			finding or deficiency identified by the EQRO.	
H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;		Full	Addressed in P/P KY.COMP.16.	
I. Providing for internal monitoring and auditing of Contractor and it subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;		Minimal	P/P KY.COMP.16 indicates that subcontractors will be responsible for conducting their own FWA activities for prevention, detection, and reporting potential FWA, while the MCO will be responsible for investigating acts of possible FWA and extracting data from the data warehouse to review for billing irregularities. The Contractor will also provide subcontractors with the same fraud and abuse detection and prevention tools and information as is afforded MCO staff, including the Compliance Hotline. The MCO collects and reviews routine and ad hoc reporting from each delegated entity. Work Process II (A) I noted a "Vendor Oversight P/P". However, this P/P was not provided, nor was documentation of subcontractor FWA activities. There were cases related to pharmacy utilization investigated by the MCO. None appeared to be referred by the subcontractor. Internal auditing and monitoring was not addressed in P/P KY.COMP.16, though methods for MCO staff to report potential FWA were included. Work Process II (A) I was noted in P/P KY.COMP.16. However, the document was not provided, nor was documentation of internal audits/monitoring.	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			No documentation of quarterly reports for internal monitoring and/or subcontractor FWA activities was provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
J. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and		Full	Addressed in P/P KY.COMP.16.	
K. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department.		Full	Addressed in P/P CC.COMP.20. Collections reports for CY 2012 were provided.	
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;		Substantial	Addressed in P/P KY.COMP.16. The monthly reports #75 SUR Algorithms were provided. All fields were blank in these reports however the Provider FWA Reports #76 contained a variety of cases identified through the review of MIS data and listed the source as "SIU software". There was no documentation related to review of grievances and appeals to mine for	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			potential FWA. **Recommendation for KY Spirit** The MCO should review member and provider grievance and appeal data to identify potential fraud or 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	Addressed in KY.COMP.16 and monthly reports Provider FWA Reports 76 and Medicaid Program Violations Report 72.	
C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;		Non-Compliance	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
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;		Non-Compliance	Not addressed in documents provided. The PIU is located in St. Louis, MO. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			finding or deficiency identified by the EQRO.	
E. Designate a contact person to work with investigators and attorneys from the Department and OIG;		Full	Addressed in P/P KY.COMP.16.	
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;		Non-Compliance	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
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;		Non-Compliance	P/P KY.COMP.16.01 referenced, however it was not provided. Evidence of conducting the verification was not provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
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		Full	The results of algorithms was evident in the file reviews (cases identified via algorithms) and in monthly Provider FWA Reports #76 (cases identified via SIU software). The	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
collected;			reports included issue, actions taken, overpayments identified and collection efforts.	
I. Have a method for collecting administratively on member overpayments that were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;		Full	Addressed in P/P CC.COMP.20.	
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	Policies and procedures were submitted to DMS.	
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;		Non-Compliance	P/P CC.CRED.03 Initial Credentialing Verification referenced, however, the P/P was not provided, nor was documentation of reporting to DMS. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
L. Have a method for recovering overpayments from providers;		Full	Addressed in P/P CC.COMP.20.	
M. Comply with the program integrity requirements		Non-Compliance	The Patient Protection and Affordable Care	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of the Patient Protection and Affordable Care Act as directed by the Department;			Act is not addressed in the documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
N. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations; and		Full	Addressed in P/P KY.COMP.16.	
O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.		Full	Evidence of working cooperatively with the Department was demonstrated in the file review.	
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	Addressed in P/P KY.COMP.16.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
COMPLAINT SYSTEM: The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process shall contain the following:				
A. Upon receipt of a complaint or other indication of potential fraud or abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;		Full	Addressed in P/P KY.COMP.16.	
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;		Full	Addressed in P/P KY.COMP.16.	
C. Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;		Full	Addressed in P/P KY.COMP.16. Addressed in P/P Health Plan Recoupment Policy.	
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	Addressed in P/P KY.COMP.16.	
E. OIG will review the referral and attached documentation and make a determination as to		Full	Addressed in P/P KY.COMP.16.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;				
F. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;		NA	OIG responsibility.	
G. If in the process of conducting a preliminary investigation, the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG;		Non-Compliance	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
H. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to the Department and the PIU for appropriate actions;		NA	OIG responsibility.	
I. If OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;		NA	OIG responsibility.	
J. If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS		NA	OIG responsibility.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and the PIU of the referral. DMS and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
K. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;		Non-Compliance	No documentation found regarding suspension of provider payments. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
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:		Minimal	Addressed in P/P KY.COMP.16. A sample of 11 program integrity files were reviewed – 8 provider files and 3 member files. Sub-requirement results are presented below. Case investigation reports were untimely; 10 of 11 files demonstrated communication between the PIU and KY Spirit Compliance with cases pending submission to the Department and OIG while undergoing MCO approval. **Corrective Action Plan** In accordance with the DMS/MCO contract	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
(1) Name and address of subject,		Full	11 of 11 files were compliant.	
(2) Medicaid identification number,		Full	11 of 11 files were compliant.	
(3) Source of complaint,		Full	11 of 11 files were compliant.	
(4) The complaint/allegation,		Full	11 of 11 files were compliant.	
(5) Date assigned to the investigator,		Minimal	The date of assignment to an investigator was only evident in one case file. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(6) Name of investigator,		Minimal	The name of the investigator was clearly identified in only one case file. The remaining files included multiple MCO and SIU staff names with no one individual designated as	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			the investigator responsible for the case. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
(7) Date of completion,		Non-Compliance	The date of completion was not identifiable in any of the files reviewed. Final reports were either not present in the file or undated. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(8) Methodology used during investigation,		Substantial	The methodology used to investigate the case was evident in 7 of 10 files reviewed. One case did not require an investigation; case was referred to the MCO by DMS for recoupment. **Recommendation for KY Spirit** The methodology to investigate individual cases should be documented in the case file.	**MCO Response:** None

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,		Minimal	Only 2 of 11 files included adequate investigative documentation and case reports. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(10) All exhibits or supporting documentation,		Non-Compliance	None of the files reviewed included exhibits, supporting documentation or a summary of attachments. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(11) Recommendations as considered necessary, for administrative action or policy revision,		Minimal	Recommendations for administrative action or policy revision were applicable to 6 files reviewed. 2 of the 6 files were compliant. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
(12) Overpayment identified, if any, and recommendation concerning collection.		Non-Compliance	Not addressed in the files reviewed. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;		Full	Monthly Member FWA Reports 77 and Provider FWA Abuse Reports 76 were provided for CY 2012.	
N. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and		Minimal	P/P KY.COMP.16 references the SIU database – Trail Tracker, but does not specify its capabilities in reference to FWA investigations. Grievance tracking is not mentioned. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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	The plan has a grievance and appeal process for members and providers, including policies and procedures and a work process.	
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	Monthly reports for CY 2012 were provided: Report 72 – Medicaid Program Violation Report 75 – SUR Algorithms Report 76 – Provider FWA Report 77 - Member FWA P/P KY.COMP.16 addresses reporting of possible FWA and reporting to and collaboration with the Department and OIG on matters of FWA.	
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	KY Spirit produced the required FWA reports on a monthly basis in 2012.	
(1) PIU Case number;		Full	Evidenced in monthly FWA reports #72, 76 and 77.	
(2) OIG Case number;		Non-Compliance	Not seen in monthly FWA reports. **<u>Corrective Action Plan</u>** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
(3) Provider/Member name;		Full	Evidenced in monthly FWA reports.	
(4) Provider/Member number;		Full	Evidenced in monthly FWA reports.	
(5) Date complaint received by Contractor;		Full	Evidenced in monthly FWA reports.	
(6) Source of complaint, unless the complainant prefers to remain anonymous;		Full	Evidenced in monthly FWA reports.	
(7) Date opened;		Full	Evidenced in monthly FWA reports.	
(8) Summary of complaint;		Full	Evidenced in monthly FWA reports.	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);		Non-Compliance	The FWA reports do not include a field for substantiation of the complaint. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
(10) PIU action taken (only provide the most current update);		Full	Evidenced in monthly FWA reports.	
(11) Amount of overpayment (if any);		Full	Evidenced in monthly FWA reports.	
(12) Administrative actions taken to resolve findings		Full	This information is included in the FWA	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of completed cases including the following information:			reports.	
(a)The overpayment required to be repaid and overpayment collected to date;		Full	Evidenced in monthly FWA reports.	
(b) Describe sanctions/withholds applied to Providers/Members, if any;		Full	This information is included in the FWA reports.	
(c) Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;		Full	This information is included in the FWA reports.	
(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 information is included in the FWA reports.	
(e) Make MIS system edit and audit recommendations as applicable.		Full	This information is included in the FWA reports.	
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		Full	Addressed in P/P K.COMP.16.	

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
end date;				
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;		Full	Addressed in P/P KY.COMP.16.	
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;		Full	Addressed in P/P KY.COMP.16.	
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	Addressed in P/P KY.COMP.16.	
E. Produce records in electronic format for review and manipulation by the Department and the OIG;		Full	Addressed in P/P KY.COMP.16.	
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and		Full	Addressed in P/P KY.COMP.16.	
G. Provide all contracted rates for providers upon request.		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
The Contractor's PIU shall have access to any and all		Non-Compliance	Not addressed in documentation provided.	**MCO Response:** None

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.			**Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or abuse cases.		Full	Addressed in P/P KY.COMP.16. Evidence of cooperation with OIG was seen in the file review cases.	
In the event no action toward collection of overpayments is taken by the Contractor after one hundred and eighty (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the Contractor takes appropriate action to collect overpayments, the Commonwealth will not intervene.		Full	Addressed in P/P KY.COMP.16.	
The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover.		Non-Compliance	Not addressed in documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	71	5	2	30
Total Points	213	10	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			**225/117=1.92**	

Reviewer Decision:

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

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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

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

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
8.4 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)				
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix J. The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.		Full	P/P KY.QI.20, EPSDT addresses this requirement including production of CMS 416 Report and Care Gap reports. Evidence was provided that EPSDT screening and participation rates are reported quarterly via CMS Form 416 and MCO Report #24. The quarterly reports show screening rates of 37%, 50%, 64% and 62% for quarters 1 through 4 respectively, and participation rates of 34%, 40%, 62% and 46% for quarters 1 through 4 respectively. **Recommendation for DMS** It is suggested that the MCO reporting requirements be revised to include quarterly reporting of CMS Form 416 as a component of MCO report #24.	**DMS Response:** DMS will review reporting recommendations to update MCO report #24 to assure that screening and participation elements reflect MCO Contract Special Program Requirements in 32.1 for EPSDT quarterly CMS 416 reporting. An additional MCO report, #93, requires annual EPSDT CMS 416 reporting. Screening and participation elements are available from this report on an annual basis as currently reported. Report #93 must be updated to reflect the requirement for quarterly reporting. DMS will provide follow up regarding MCO reports #24 and #93 report revision timelines.
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:		Full	P/P KY.QI.20 indicates that there is provider education, plan employee education, and provider interventions for improvement to meet the standards to provide EPSDT services.	
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	Addressed in P/P KY.UM.01.01. The plan conducts orientation education with new plan providers including information specific to EPSDT services and programs.	

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.		Full	The Member Handbook has a section on EPSDT that provides written information regarding who is eligible, and a basic summary of services with a phone number if assistance is needed to schedule an appointment. New Member Welcome Packet (EPSDT Brochure) provides general member education. P/P KY.QI.20 lists Member Interventions for Improvement listing interventions used to communicate with members regarding EPSDT. The MCO provided additional information: The Care Gap report is reviewed monthly to identify members with service needs or gaps in care. The EPSDT Coordinator performs telephonic outreach along with mail based outreach to explain the EPSDT periodicity schedule and educate on the importance of early intervention services. Quarterly reports (MCO report #24) for Q1-Q4 2012 describe outreach efforts including: group presentations, one-to-one outreach, distribution of brochures and reminder magnets, outreach calls and service reminders.	
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.		Minimal	EPSDT policy/procedure does not include right to appeal decisions related to EPSDT services. Member Handbook includes the member's right to appeal decisions related to Medicaid services, but does not specify EPSDT services.	**MCO Response:** None

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			UM File Review Five UM decisions related to EPSDT (child members) were reviewed. All 5 files were completed timely and were compliant with UM contract requirements. Appeal File Review Two member appeals related to EPSDT (child members) were reviewed. Timeliness of resolutions was unable to be determined due to lack of dated appeal requests in the files. Notices lacked required language informing members of the opportunity to examine the case file, and the opportunity to present evidence. The content of resolution notices was not customized to the nature of the individual appeal, and language was unclear or not written at an appropriate reading level. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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		Full	P/P KY.QI.20 addresses this requirement. Also addressed in the Member Handbook and the Provider Manual. Providers have access to information on potential care gaps through the provider web portal. The portal informs	

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Appendix J.			providers of their members with possible care gaps based upon claims data.	
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.		Full	Addressed in P/P KY.QI.20 EPSDT. This policy lists Provider Interventions for Improvement including oversight and education of providers to monitor compliance of EPSDT periodicity and services. Also addressed in the Provider Manual.	
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	Addressed in P/P KY.QI.20 and P/P KY.CONT.03, Single Case Agreement "SCA".	
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J.		Full	P/P KY.UM.01.01 addresses this requirement.	
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.		Non-Compliance	Documents provided do not address tracking of acceptance and refusal of EPSDT services. P/P addresses monitoring of receipt/non-receipt of services but does not include acceptance and refusal by members. Evidence of a tracking system not provided. **Corrective Action Plan**	**MCO Response:** None

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.		Full	P/P KY.QI.20 describes Impact Pro, a risk stratification program which identifies care gaps for the EPSDT population by utilizing claims data. These care gaps are viewable to member services and case management staff to enable follow-up contacts. On a case-by-case basis, members with continued non-compliance with EPSDT services are referred to case management. P/P KY.CM.01 states: For EPSDT Special Services, which require prior authorization, the CM will follow-up with the member within 5 business days of the scheduled appointment to ensure appointment was kept and to facilitate ongoing services as indicated. If appointment was missed, the CM will assist member to reschedule and arrange transportation if needed.	
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		Full	Addressed in Provider Manual.	

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
referral compliance and reports from referral physicians or providers.				
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.		Full	Addressed in P/P KY.QI.10, Continuity & Coordination Between Medical and Behavioral Health Care.	
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.		Full	P/P KY.UM.24 Continuity and Coordination of Services describes the plan's process for ensuring that appropriate referrals and linkages are made for members including covered and non-covered services while maintaining the member's privacy.	
K. Participate in any state or federally required chart audit or quality assurance study.		Full	Addressed in the Quality Improvement Program Description.	
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.		Full	Per P/P KY.QI.20, Centene University Course #142 is a general overview training presentation for EPSDT. EPSDT Provider Education Workshops were in February and March 2012. The Provider Manual outlines the EPSDT Program and plan website has information under Provider Resources section. Addressed in P/P KY.QI.20. Per the MCO, practitioner training materials include information specific to EPSDT services and programs. Kentucky Spirit's Provider Relations	

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			representatives conducted 6 provider educational sessions in February and March, 2012 which is part of the provider orientation and includes information regarding EPSDT services and the EPSDT periodicity schedule. Providers can also access information regarding the EPSDT program and covered EPSDT services and provider requirements in the Provider Handbook, and via the Plan website at www.kentuckyspirithealth.com under the Provider Resource section.	
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.		Substantial	P/P Encounter Submission Policy & Procedure states that files are checked for compliance with state requirements (P/P is not numbered or dated). Evidence of reporting of encounter data to DMS provided. P/P KY.QI.20 EPSDT states there are Control Monitoring Reports submitted to include CMS-416 forms quarterly. Quarterly reports (MCO report #24) provided for review. Annual report was submitted to DMS in March 2013. KY Spirit reported an EPSDT screening rate of 68% for the Categorically Needy category. Across age groups, the screening rate ranged from 12% (19-20 years of age) to 93% (3-5 years of age). KY Spirit reported an EPSDT participation rate of 46% for the Categorically Needy category. Across age groups, the participation rate ranged from 9% (19-20 years of age) to 93% (age < 1 year).	**MCO Response:** None

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			KY Spirit did not provide EPSDT screening and participation rates for the Medically Needy category. **Recommendation for KY Spirit** The MCO should report EPSDT screening and participation rates for the Categorically Needy and Medically Needy categories, and total screening and participation rates combining the categories.	
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.		Full	Job Description for position was provided. EPSDT Coordinator position in place. One individual reports to this position.	
22.1 Required Functions				
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.		Full	Addressed in the EPSDT Coordinator position description.	
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.		Substantial	P/P KY.QI.20 includes procedures for reporting. Quarterly CMS-416 and MCO Report #24 reports were reviewed. Annual report was submitted to DMS in March 2013. KY Spirit reported an EPSDT screening rate of 68% for the Categorically Needy category. Across age groups, the screening rate ranged from 12% (19-20 years of age) to 93% (3-5 years of age). KY Spirit reported an EPSDT	**MCO Response:** None

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Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			participation rate of 46% for the Categorically Needy category. Across age groups, the participation rate ranged from 9% (19-20 years of age) to 93% (age < 1 year). KY Spirit did not provide EPSDT screening and participation rates for the Medically Needy category. **Recommendation for KY Spirit** The MCO should report EPSDT screening and participation rates for the Categorically Needy and Medically Needy categories, and total screening and participation rates combining the categories.	

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	16	2	1	1
Total Points	48	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		**53/20=2.65**		

Reviewer Decision:

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

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

Documents

Policies/procedures for:

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

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

File Review

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

Reports

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

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

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
5.3 Delegations of Authority			KSHP utilizes the following subcontractors and delegated services: 1. Cenpatico (behavioral health) 2. MCNA (dental services) 3. NIA (radiology services management) 4. Nursewise (24 hour nurse line) 5. Nurtur (disease management) 6. Opticare (vision services) 7. US Script (pharmacy benefit management)	
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.		Substantial	Policies and procedures for subcontractor oversight were not submitted for review. Subcontractor Oversight Committee description was not submitted for review. However, 6/7 delegate contracts and quarterly subcontractor monitoring meeting minutes for all delegates were submitted for review. Only the latest contract amendment was provided for NIA. **<u>Recommendation for KY Spirit</u>** The MCO should provide complete documentation for review. Delegate contracts for 6 delegates were submitted upon request/at time of on-site review. The MCO should submit full contracts (not only the most recent	**MCO Response:** None

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			amendments) in advance of review. In addition, NCQA/URAC Certificates of Accreditation were submitted for review, but survey reports were not.	
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	All 7 contracts/amendments specified delegated activities, reporting responsibilities and sanctions if performance was inadequate.	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.		Full	All 7 contracts/amendments with KY Spirit were initiated October 1, 2011. Per the MCO, all of the delegated vendors were doing business with other plans through Centene. As such the "pre-delegation" report is represented by annual audits for each vendor. The 7 annual audits were conducted March 15-16, 2012 through August 15-16, 2012.	
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	All 7 contracts/amendments specified processes by which the MCO provided ongoing monitoring and annual evaluation. Required reporting was enumerated for each delegate. Comprehensive annual audits for each delegate were reviewed.	
D. If the Contractor identifies deficiencies or areas for		Substantial	6 of 7 contracts/amendments contained	**MCO Response:** None

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
improvement, the Contractor and the Subcontractor shall take corrective action.			language regarding oversight obligations of the MCO and the issuance of corrective action plans. The 7th contract (NIA) contained only the latest amendment to the contract. However, the 2012 annual audit revealed NIA had been placed on 2 quality improvement plans (QIPs) (Recredentialing and UM Decision and Notification Standards). **Recommendation for KY Spirit** Complete contracts should be provided.	
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.		Substantial	6 of 7 contracts/amendments contained the required language. The 7th contract file (NIA) contained only the latest amendment to the contract and did not address this requirement. **Recommendation for KY Spirit** Complete contracts should be provided.	**MCO Response:** None
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.		Full	All 7 contracts/amendments contained the required language.	
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		Full	All 7 contracts/amendments contained the required language.	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.				
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.		Full	All 7 contracts/amendments contained the required language.	
7.2 Requirements				
All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with		Non-Compliance	Not addressed in the documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse	**MCO Response:** None

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.			quality finding or deficiency identified by the EQRO.	
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;		Full	All 7 contracts/amendments contained the required language.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;		Full	All 7 contracts/amendments contained the required language.	
C. Specify procedures and criteria for extension, renegotiation, and termination;		Substantial	6 of 7 contracts contained the required language. The 7th contract (NIA) contained only the latest amendment to the contract and did not address this requirement.	**MCO Response:** None

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for KY Spirit Complete contracts should be provided.	
D. Specify that Subcontractors use only Medicaid providers in accordance with this Contract;		Full	All 7 contracts/amendments contained the required language.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;		Full	All 7 contracts/amendments contained the required language.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;		Full	All 7 contracts/amendments contained provisions regarding ongoing monitoring, reporting, and annual review. Oversight committee meeting minutes showed all subcontractors were discussed quarterly. Annual audits demonstrated comprehensive review of all contractors annually.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;		Substantial	4 of 7 contracts/amendments contained language specifically prohibiting incentives for withholding Necessary Covered Services. **Recommendation for KY Spirit** All contracts should include this requirement.	**MCO Response:** None
H. Contain a prohibition on assignment, or on any		Full	All 7 contracts/amendments contained	

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
further subcontracting, without the prior written consent of the Department;			the required language.	
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	All 7 contracts/amendments contained the required language.	
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	All 7 contracts/amendments contained the required language.	
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	All 7 contracts/amendments contained the required language.	
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,		Full	All 7 contracts/amendments contained the required language.	
(2) all QAPI requirements,		Full	All 7 contracts/amendments contained the required language.	
(3) all record keeping and reporting requirements,		Full	All 7 contracts/amendments contained the required language.	
(4) all obligations to maintain the confidentiality of information,		Full	All 7 contracts/amendments contained the required language.	
(5) all rights of Finance, the Department, the Office of		Full	All 7 contracts/amendments contained	

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,			the required language.	
(6) all indemnification and insurance requirements, and		Full	All 7 contracts/amendments contained the required language.	
(7) all obligations upon termination;		Full	All 7 contracts/amendments contained the required language.	
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	All 7 contracts/amendments contained provisions regarding ongoing monitoring, reporting, and annual review. Oversight committee meeting minutes showed all subcontractors were discussed quarterly. Annual audits demonstrated comprehensive review of all contractors annually.	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.		Minimal	All 7 subcontractors/amendments demonstrated certification of NCQA or URAC accreditation. No NCQA or URAC survey reports were submitted for review. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR	**MCO Response:** None

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.		Full	All 7 contracts/amendments contained the required language regarding subcontractor QI processes.	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.		Full	All 7 contracts/amendments contained the required language.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.		Full	All 7 contracts/amendments contained the required language.	
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.				
7.3 Disclosure of Subcontractors				

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The 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.		Non-Compliance	No evidence found. Policies and Procedures for Subcontractor Oversight were not submitted for review. Documentation of secondary subcontractors meeting these criteria not found. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** None
7.4 Remedies				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.		NA	DMS responsibility.	

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

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	26	5	1	2
Total Points	78	10	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		**89/34=2.62**		

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

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

Documents

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

Reports

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

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

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

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount that is beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue their existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.		Full	Addressed in P/P KY.CM.01, Care Management Program.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.		Full	Addressed in P/P KY.CM.01.	
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.		Full	Guidelines for Care Coordination are found in the following policies: KY.CM.01 (Care Management Program), CC.CM.11.01 (Coordination with Nurtur DM Programs), KY.CM.14.01 (Members with Special Health Care Needs), KY.CM.14.02 (Management and Tracking of Guardianship Members) and KY.CM.14.03 (Management and Tracking of Foster Care Members).	
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.		Full	Addressed in P/P KY.CM.01.	
34.3 Care Coordination				
The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for Members.		Full	Addressed in P/P KY.CM.01. <u>Care Coordination File Review</u> 20 member files were reviewed. All contained a Comprehensive Assessment. **<u>Recommendation for DMS</u>** It is suggested that future file reviews include a subset of members enrolled in complex case management. Although the files selected for review included members with multiple chronic conditions, their	**DMS Response:** DMS agrees with IPRO's recommendation. Appropriate files will be requested from each MCO for the next compliance review.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			conditions were relatively stable. It would be useful to assess the effectiveness of services provided to members with more complex needs.	
Care coordination is a process to assure that the physical and behavioral health needs of the Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.		Full	The primary elements for Care Coordination are found in the following policies: KY.CM.01 (Care Management Program), CC.CM.11.01 (Coordination with Nurtur DM Programs), KY.CM.14.01 (Members with Special Health Care Needs), KY.CM.14.02 (Management and Tracking of Guardianship Members) and KY.CM.14.03 (Management and Tracking of Foster Care Members).	
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical,		Full	Identification, comprehensive assessment, referral to case management and care plan development for members with special health care needs are addressed in P/Ps KY.CM.01 and KY.CM.14.01 (Members with Special Health Care Needs).	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.		Full	Elements of the Care Coordination Assessment are addressed in P/Ps KY.CM.01 and KY.CM.14.01. Care Coordination File Review 20 of 20 care coordination files reviewed included completed comprehensive assessments.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.		Full	Addressed in P/P KY.CM.01. Care Coordination File Review Member files reviewed included a care plan with established goals.	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.		Minimal	Addressed in P/P KY.CM.01. The policy (inclusive of, but not specific to, DCBS clients) states 3 measures, quantitative results, benchmarks and plans for intervention will measure program effectiveness, while feedback and complaints will measure satisfaction. Reports meeting this description were not submitted. P/P KY.CM.14.03, Management and Tracking of Foster Care and Subsidized Adoption Members, states DCBS "members are	**MCO Response:** P/P KY.CM.14.03 Management and Tracking of Foster Care and Adoption Members has been updated to include: The Plan shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population. In addition, a survey and subsequent reporting schedule will be created in 2013 to track, analyze, report, and when indicated, develop

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			managed in a consistent manner, with appropriate interventions, tracking measures and documentation to facilitate the monitoring of outcomes." Monthly DCBS Reports #65 (March through December 2012) were submitted. These reports contained line-lists and tallies of DCBS members, case management enrollment and utilization of services. The reports did not contain indicators or analysis or address member satisfaction. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population. Monthly Report # 65 is completed per the instructions of DMS. The Plan is not required to include information regarding indicators or analysis or address member satisfaction. Report # 65 was provided as supporting evidence of access to care coordination services for DCBS clients. With submission of additional documentation and this clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.		Full	Addressed in P/P KY.CM.01 and Member and Provider Handbooks.	
35.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral,				

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.		Full	P/P KY.CM.14.01 defines categories of members with disabilities, chronic or complex medical, and/or, behavioral health, conditions and Children with Special Health Care Needs.	
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.		Full	Addressed in P/P KY.CM.14.01.	
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.		Full	Addressed in P/P KY.CM.14.01.	
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age		Substantial	Addressed in the following policies: KY.CM.01, KY.CM.14.01, KY.CM.14.03 (Management and Tracking of Foster Care Members), KY.CM.14.02 (Management and Tracking of Guardianship Members).	**MCO Response:** P/P KY.CM.01 Case Management Program has been updated to include the following contract language: CM Programs are open to any Plan member with indications of special health care needs

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of 65; Homeless (upon identification); individuals with chronic physical health illnesses; and individuals with chronic behavioral health illnesses.			Language addressing members who are homeless or over the age of 65 years was not found. **Recommendation for KY Spirit** Update policies and procedures to include the required populations.	(ISHCN), to include identification and inclusion of the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; and individuals with chronic behavioral health illnesses. With the revisions to this policy, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.		Full	Addressed in P/P KY.CM.14.01. Educational resources and content are described in P/P CC.CM 12, Disease-Specific Education Materials.	
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.		Full	Addressed in P/P KY.CM.14.01.	
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of		Full	Addressed in P/P KY.CM.14.01.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
treatment or regular care monitoring.				
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.		Minimal	Practice guidelines are generally referenced in Policies CC.CM.12 Disease Specific Educational Materials (Policy) and KY.QI 20 EPSDT Services (Procedure, C. Provider Interventions for Improvement). Practice Guidelines are generally referenced throughout the Provider Manual (P. 8, 28, 38, 40, 46, 59, 67, 71, 72). Aside from EPSDT and the APA Periodicity Schedule, no specific clinical guidelines are named, submitted or found, and none address ISHCN. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** The Plan currently follows a policy for Clinical Practice Guidelines. CC.QI.08 – Preventive Health and Clinical Practice Guidelines. This policy includes specific clinical practice guidelines for health services relevant to the populations served, including consideration of the needs of ISHCN. CC.QI.08 states that the Plan will utilize clinical practice guidelines to provide guidance in the provision of acute and chronic physical and behavioral health care services. This information is being submitted in a quarterly report to DMS. Report # 23 – Evidence Based Guidelines for Practitioners. With submission of additional documentation and this clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
35.2 DCBS Protection and Department for Aging and Independent Living DAIL Protection and Permanency Clients				

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.		Minimal	Service Plans, Health Risk Screening, Referrals to CM and Care Coordination are addressed in P/P KY.CM.03 and KY.CM.02. Monthly DCBS Reports #65 (March through December 2012) submitted to the Department were reviewed. These reports contained line-lists and tallies of DCBS members, case management enrollment and utilization of services. As of December, 4% (108/2506) of DCBS members and 66% (83/126) of DAIL members were enrolled in CM. <u>DCBS Service Plan File Review</u> 20 member files were reviewed for DCBS Service Plans. 16 /20 files contained a detailed Service Plan; where not available, KY Spirit submitted the Health Plan Health Risk Assessment. Information was used from the service plan and/or health risk assessment to determine medical needs and to identify members for case management. None of the files reviewed required case management. Files demonstrated ongoing care coordination when appropriate. 13/20 noted a BH diagnosis, ongoing BH	**MCO Response:** Based on the information provided, the files reviewed did demonstrate ongoing care coordination when appropriate as required by the Contract. The Plan is unable to develop a Corrective Action Plan in regard to availability of Service Plans as the process is reliant upon the Department for Community Based Services (DCBS) to provide the correctly completed service plans in a timely manner. As discussed during the review, DCBS is not consistent with providing service plans on all members enrolled to the Plan. The Plan is in the process of developing a new MCO report that will be a required monthly submission to DMS. Report # 38 – EPSDT Special Services - is a new reporting requirement for 2013. This report will contain information relative to EPSDT Special Services for procedure codes billed, count of members utilizing each procedure code, total claims dollars paid, unduplicated number of providers billing per code and any new codes added during the report month for each reporting period. The Plan will began submitting this report to DMS for the May 2013 reporting period, due in June 15, 2013. This report will allow for tracking of well visits and EPSDT services by procedure code.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			care and no current needs. 6/20 noted no diagnosis (the remaining individual was diagnosed with glaucoma). DCBS Claims File Review IPRO also conducted a claims review of DCBS members: all professional/outpatient claims, documentation of outreach efforts including outreach related to EPSDT services, and any case management or care coordination files for selected members were requested. Twenty files were reviewed with the following results: Claims data were not submitted. Provision of well visits and EPSDT services was not able to be determined. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO. **Recommendation for DMS** Under the Department's 1915(b) waiver, and consistent with federal requirements at	With submission of additional documentation and this clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination. **DMS Response:** DMS agrees with IPRO's recommendation. DMS will: ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.

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

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	
35.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.		Substantial	P/P KY.CM.02 does not include language regarding the DAIL level of responsibility for making medical decisions. **Recommendation for KY Spirit** Update the policy and ensure Service Plans indicate the DAIL level of responsibility for making medical decisions.	**MCO Response:** P/P KY.CM.14.02 – Management and Tracking of Guardianship Members has been updated to include the following: Upon the Member's Enrollment to the Plan, DAIL shall provide the Plan with a service plan for each adult in Guardianship, indicating the DAIL level of responsibility for making medical decisions for the Member. If the service plan identifies the need for case management, the Plan will work with Guardianship staff and/or the Member to develop a case management care plan, as appropriate. With the revisions to this policy, the plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
35.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in		Full	Addressed in P/P KY.CM.03.	**DMS Response:** DMS agrees with IPRO's

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.			DCBS Service Plan File Review 20 DCBS files were reviewed for evidence of service plans and discussion of health care issues at monthly DCBS/KSHP meetings. Upon interview, KY Spirit staff reported DCBS has rescheduled the meetings for every other month, with DCBS hosting the meeting and keeping the minutes. 16 of 20 files included a service plan. The remaining 4 files included a health risk assessment. **Recommendation for DMS** Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The MCOs are responsible for ongoing care coordination for these members including assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to	recommendation. DMS will: ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.		Full	Addressed in P/P KY.CM.03. <u>DCBS Service Plan File Review</u> None of the files reviewed required case management services.	
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a		NA	Addressed in P/P KY.CM.03.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
newly identified health care issue) or modification of an existing case management care plan.			DCBS Service Plan File Review None of the files reviewed required case management services.	
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.		Substantial	Language regarding co-signature of service plans, disagreement and resolution were not found in documentation provided. DCBS Service Plan File Review 16 of 16 service plans contained a DCBS staff name or signature. All contained KY Spirit notes, but none were signed. No members in the sample were referred to CM. **Recommendation for KY Spirit** Update policy to require KY Spirit signature on service plans. Update policy to include procedures regarding disagreement with the service plan and steps for resolution. **Recommendation for DMS** Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The	**MCO Response:** P/P KY.CM.14.02 – Management and Tracking of Guardianship Members and P/P KY.CM.14.03 – Management and Tracking of Foster Care Members have been updated to reflect the following recommendation: The Plan's Foster Care or Guardianship liaison or his/her designee will sign the Service Plan upon receipt at the Plan. If it is determined that there is a discrepancy in the information provided on the service plan, the Plan's Foster Care or Guardianship Liaison will immediately notify the State Guardianship worker and facilitate a case review in an effort to resolve any concerns. If DCBS and Plan staff cannot reach agreement on the Member's service plan, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Plan staff will be forwarded to a designated county DCBS worker. That DCBS staff member shall work with the designated Plan representative and a designated Department representative, if

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			MCOs are responsible for ongoing care coordination for these members including assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process. With the revisions to this policy, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination. **DMS Response:** DMS agrees with IPRO's recommendation. DMS will: ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted,

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				have additional meetings and amend process.
35.5 Children Receiving Adoption Assistance				
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.		NA	Addressed in P/P KY.CM.03. 20 member files were reviewed for DCBS Service Plan; none were receiving adoption assistance. **Recommendation for DMS** Under the Department's 1915(b) waiver, and consistent with federal requirements at 42 CFR 438.208, children in/or receiving foster care or adoption assistance and adult guardianship clients are identified as individuals with special health care needs (ISHCN). The MCO contract requires that the MCOs identify ISHCN so that the MCO can facilitate access to appropriate services, including case management services. The MCOs are responsible for ongoing care coordination for these members including assuring access to social, community, medical and behavioral health services. It is critical that the MCOs have access to baseline information about these individuals to enable timely and appropriate referrals and interventions to assure access to	**DMS Response:** DMS agrees with IPRO's recommendation. DMS will: ▪ review DCBS contract ▪ review MCO contract ▪ discuss findings with DMS ▪ meet with DCBS to discuss their contract scope of work and responsibilities ▪ meet with each MCO to discuss their scope of work and contract responsibilities ▪ meet with DCBS, and each MCO to review service plan process and determine what barriers exist to prevent completion of the service plans ▪ review process for completing the service plans ▪ make changes as warranted ▪ monitor the progress and if warranted, have additional meetings and amend process.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			needed services. DCBS/DAIL service plans are the key source of this baseline information and ongoing communication with DCBS/DAIL staff is essential to coordinate the most appropriate services needed by individual members. DCBS/DAIL staff are key members of the care coordination team, working with the MCOs to identify changing needs, assess the effectiveness of interventions taken, and modify care plans accordingly. It is strongly recommended that all relevant entities (DCBS, DAIL, DMS, MCOs) establish mutually-agreeable communication and information-sharing protocols to remedy this situation in order to comply with federal and state requirements, and most importantly, permit active, effective care coordination for these members.	
32. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.		Non-Compliance	Not addressed in the documentation provided. P/Ps CC.CM.03, Abuse and Neglect Reporting and CC.MBRS.12, Physical Abuse, Sexual Abuse and Rape Calls direct members to the ER. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the	**MCO Response:** The Plan has 2 physicians in network that have the capacity to perform a forensic pediatric sexual abuse examination upon request. *Dr. Lisa Pfitzer *Dr. Melissa Currie. Both are certified members of the University of Louisville Pediatric Forensic Medicine Team

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	and are PAR providers. These providers were in network at the time of review, however in the absence of clear direction it was not understood what was being requested for this item. With the provision of evidence of contracted providers, the Plan requests this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
32.8 Pediatric Interface				
The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.		Non-Compliance	Not addressed in the documentation provided. P/P KY.CM.01 states only that CM may contact the school nurse or other personnel to monitor implementation of care plan and progress toward desired outcomes. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** P/P KY.CM.01 – Case Management Program has been updated to include: The Plan will make reasonable effort to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Plan provided services. The Plan will monitor the continuity and coordination of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Plan coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				summer months, the Plan will be responsible for providing all Medically Necessary Covered Services With the revisions to this policy, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.		Non-Compliance	Not addressed in the documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** P/P KY.CM.01 – Case Management Program has been updated to include: School-Based Services provided by public health departments are included in Plan coverage. In situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Plan will be responsible for providing all Medically Necessary Covered Services. The Plan will make reasonable effort to coordinate with the schools to ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child. With the revisions to this policy, the Plan requests that this element be revised to reflect

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.		Non-Compliance	Not addressed in the documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** P/P KY.CM.01 – Case Management Program has been updated to include: The Plan will make reasonable efforts to coordinate services between the First Steps program and Plan coverage to provide early intervention services to children from birth up to age three who have developmental disabilities or delays and in an effort to ensure early and ongoing provision of necessary services. With the revisions to this policy, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
In order for Contractor and its Providers to effectively manage care for Members who qualify for these services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share		Non-Compliance	Not addressed in the documentation provided. **Corrective Action Plan** In accordance with the DMS/MCO contract	**MCO Response:** P/P KY.CM.01 – Case Management Program has been updated to include: The Plan will make reasonable efforts to coordinate the care provided through special

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
information with early intervention/school-based service providers with appropriate permission from parents.			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	resource programs for identified children who are receiving these services, in order to share information with early intervention/school-based service providers with appropriate permission from parents. **IPRO Comments:** No change in review determination.
Services provided under HANDS shall be excluded from Contractor coverage. HANDS is a home visitation program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.		NA	DMS responsibility.	
37.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.		Full	Monthly DCBS Reports #65 (March through December 2012) containing the required elements were submitted for review.	

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

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	19	3	3	5
Total Points	57	6	3	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**66/30=2.20**		

Reviewer Decision:

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

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Case Management/Care Coordination
Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

Monthly/quarterly reports of service plan reviews conducted for DCBS and DAIL clients
Number of DCBS and DAIL clients enrolled in the MCO as of the last day of the review period (December 31, 2012)
Number of DCBS and DAIL clients enrolled in the MCO who are enrolled in case management/care coordination as of the last day of the review period (December 31, 2012))
Monthly reports of Foster Care cases

File Review

Care Coordination files for a random sample of cases selected by EQRO
Logs of DCBS/MCO and DAIL/MCO meetings to review members
DCBS and DAIL Service Plans for a sample of cases selected by EQRO
DCBS Case Management files/claims records

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

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.		Full	P/P KY.MBRS.25, Member Rights and Responsibilities addresses contract requirements. The Member Handbook includes a section titled "Members Rights and Responsibilities" addressing this requirement.	
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.		Full	Addressed in P/P KY.MBRS.25 and the Provider Manual.	
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	Addressed in P/P KY.MBRS.25, Member Handbook and Provider Manual.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;		Full	P/P KY.ELIG.03, Primary Care Provider (PCP) Selection and Change and the Member Handbook address this requirement.	
C. Consent for or refusal of treatment and active participation in decision choices;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The Member Handbook and Provider Manual state the member rights and responsibilities and address these requirements. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	determination.
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address these requirements. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.
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;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Manual state the member rights and responsibilities and address these requirements. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	
F. Timely access to care that does not have any communication or physical access barriers;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.
I. Timely referral and access to medically indicated specialty care; and		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address this	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:		Full	Addressed in P/P KY.MBRS.25, Member Handbook and Provider Manual.	
B. Abide by the Contractor's and Department's policies and procedures;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**IPRO Comments:** No change in review determination.
C. Become informed about service and treatment options;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.
D. Actively participate in personal health and care decisions, practice healthy life styles;		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	determination.
E. Report suspected Fraud and Abuse; and		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual.	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.
F. Keep appointments or call to cancel.		Substantial	P/P KY.MBRS.25 describes how the plan provides these rights to members, but does not address these actual rights and responsibilities. The Member Handbook and Provider	**MCO Response:** The policy will be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the Provider Manual. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Manual state the member rights and responsibilities and address this requirement. **Recommendation for KY Spirit** The policy should be revised to include the Member's Rights and Responsibilities as written in the Member Handbook and the 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	Addressed in P/Ps KY.MBRS.25 and KY.ELIG.03, PCP Selection and Change. The plan also provided the Member Handbook and Print Screen of their online management system indicating that the plan does track the date sent and the date received.	
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	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation and P/P KY.MBRS.25.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.		Substantial	P/P KY.MBRS.25 describes that all plan members receive a handbook upon enrollment. The policy does not include that the handbook also is available electronically. **Recommendation for KY Spirit** The plan should include in the policy that the Member Handbook is available	**MCO Response:** The policy will be revised to include that the handbook also is available electronically. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			electronically.	
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.		Non-Compliance	P/P KY.MBRS.25 does not specify whether the handbook is reviewed by the plan annually or how changes to the handbook are addressed. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** The policy will be revised to include handbook annual renewal process and how to address changes. **IPRO Comments:** No change in review determination.
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:		Full	P/P KY.MBRS.02 and P/P KY.MBRS.25 address this requirement.	
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;		Substantial	The Member Handbook addresses these requirements. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
B. The procedures for selecting a PCP and scheduling an initial health appointment;		Full	P/P KY.ELIG.03 PCP meets this requirement.	
C. The name of the Contractor and address and		Substantial	P/P KY.MBRS.09 addresses this	**MCO Response:** Policy will be revised to include this

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;			requirement, however the policy does not indicate that this information is available in the Member Handbook. The Member Handbook addresses this requirement. **Recommendation for KY Spirit** The plan should include this information in the policy.	information is available in Member Handbook. **IPRO Comments:** No change in review determination.
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
E. Member rights and responsibilities including reporting suspected fraud and abuse;		Full	P/P KY.MBRS.25 addresses this requirement. The Member Handbook addresses this requirement.	
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
G. Procedures for obtaining transportation for both		Substantial	The Member Handbook addresses this	**MCO Response:** Policy will be updated to include

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
emergency and non-emergency situations;			requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
I. Procedures for arranging EPSDT for persons under the age of 21 years;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
J. Procedures for obtaining access to Long Term Care Services;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			new policy specific to the handbook.	
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
L. A list of direct access services that may be accessed without the authorization of a PCP;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
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;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
N. Information about how to access care before a PCP is assigned or chosen;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit**	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the 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;		Substantial	The Member Handbook does address the right to a second opinion and information on how to do so for "your treatment choice", an "issue", or a "certain services or methods". There is no specific reference to surgical procedures, complex and/or chronic conditions. **Recommendation for KY Spirit** Include these specific issues for obtaining second opinions in the Member Handbook and also specify in a policy related to the Member Handbook.	**MCO Response:** Policy and Member Handbook will be revised to include the specifics of this requirement. **IPRO Comments:** No change in review determination.
P. Procedures for obtaining Covered Services from non-network providers;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
T. Information on the availability of health education services;		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
U. Information deemed mandatory by the Department; and		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for KY Spirit The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	determination.
V. The availability of care coordination, case management and disease management provided by the Contractor.		Substantial	The Member Handbook addresses this requirement. P/Ps provided do not address this requirement. **Recommendation for KY Spirit** The plan should include this information in the current P/P KY.MBRS.25 or create a new policy specific to the handbook.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
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.		Substantial	P/P KY.UM.01.01, Covered Benefits and Services address all requirements, except informing the member in writing at the time of enrollment of this right. The Member Handbook addresses this requirement. **Recommendation for KY Spirit** The plan should amend the policy to include the requirement in its entirety.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
22.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Standard Time (EST). The call center shall meet		Substantial	P/P KY.MBRS.09, Member Service Calls/Hotline describes the call center and staffing.	**MCO Response:** Policy will be amended to include if a Contractor has separate telephone lines for different Medicaid populations, the Contractor will report performance for each individual line

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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**
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.			P/P KY.MSPS.21, Telephone Call Response Standards indicates that the Member and Provider Services Department will monitor call volume and ensure service levels are met for the average speed of answer, abandoned call rate and blockage rate and that at least 80% of calls are answered within 30 seconds. There is no documentation in the policy of separate phone lines or information being given by the Department. **Recommendation for KY Spirit** The plan should amend the policy to include these requirements.	separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards. **IPRO Comments:** No change in review determination.
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).		Full	P/P KY.MSPS.21 addresses this requirement with the use of NurseWise, the plan's 24-hour nurse information and triage line available 24/7.	
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	P/P KY.MSPS.21 addresses this requirement. Monthly reports were submitted by the plan. All rates reported monthly were within required performance rates.	
Appropriate foreign language interpreters shall be		Substantial	P/P KY.MSPS.21 addresses this	**MCO Response:** Policy will be created that

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.			requirement. P/P KY.MBRS.25 addresses requirements related to member materials and treat all members equally and addresses that the plan representatives do not discriminate against any potential member because of race, creed, age, color, sex, religion, culture, national origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or requirements for health services. P/P KY.MBRS.09, Member Services Calls/Hotline addresses that these representatives are thoroughly trained in Cultural Competency and other topics to meet members' needs. The Provider Manual provides information regarding ongoing training as per the requirements. None of the policies provided had specific documentation of ongoing training for providers on matters related to meeting the needs of the economically disadvantaged and culturally diverse individuals. **<u>Recommendation for KY Spirit</u>** The Plan should have a policy that specifically addresses the ongoing training	specifically addresses the ongoing training for providers. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			for providers.	
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.		Non-Compliance	Policies provided did not address this requirement. The Member Handbook and Provider Manual did not contain information related to service locations' requirements. Immediate access to medical records is not defined in policies provided. The Member Handbook indicates the member has access to their medical record with no timeframe associated. This is also evident in the Provider Manual wherein immediate access is not addressed. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy, Member Handbook and Provider Manual will be revised to include these requirements. **IPRO Comments:** No change in review determination.
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;		Full	P/P KY.MBRS.25 addresses this requirement. The Member Handbook also addresses this requirement.	

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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**
B. Monitoring the selection and assignment process of PCPs;		Full	P/P KY.ELIG.04, PCP Auto-Assignment addresses this requirement. The Member Handbook provides the Member Services contact information to address this requirement.	
C. Identifying, investigating, and resolving Member Grievances about health care services;		Substantial	P/P KY.MBRS.09 describes how Member Services serve as the primary vehicle to which members can access their health care benefits and services. The policy also states that the Member Service Representatives (MSR) will attempt to resolve all member inquiries or concerns; however this specific requirement of grievances is not addressed. The Member Handbook provides the Member Services contact information to address this requirement. **Recommendation for KY Spirit** Amend the policy to address the specific requirement.	**MCO Response:** Policy will be revised to address this specific requirement. **IPRO Comments:** No change in review determination.
D. Assisting Members with filing formal Appeals regarding plan determinations;		Substantial	P/P KY.MBRS.09 describes how Member Services will address concerns, but does not refer to this requirement. The Member Handbook provides the Member Services contact information to address this requirement.	**MCO Response:** Policy will be revised to address this specific requirement. **IPRO Comments:** No change in review determination.

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for KY Spirit Amend the policy to address the specific requirement.	
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;		Substantial	P/P KY.ELIG.04 describes that a member ID card will be sent. The Member Handbook provides the Member Services contact information to address this requirement. Although identified as being sent with auto-assignment of a PCP, it is not addressed as a Member Services responsibility in the policy. **Recommendation for KY Spirit** The policy should be amended to address this requirement.	**MCO Response:** Policy will be revised to address this specific requirement. **IPRO Comments:** No change in review determination.
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;		Full	P/P KY.MBRS.09 addresses this requirement. The Member Handbook addresses this requirement.	
G. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;		Full	P/P KY.MBRS.09 describes how all members' calls of any concerns or inquiries will be addressed. P/P KY.MBRS.03 describes how members have time to select providers and how assistance is available from plan. The Member Handbook addresses this	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement.	
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested 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	P/P KY.ELIG.03 addresses requirement. P/P KY.MBRS.09 addresses requirement for access to other notification methods. Member Handbook addresses access to handbook and services.	
I. Explaining or answering any questions regarding the Member Handbook;		Full	P/P KY.MBRS.02 and P/P KY.MBRS.09 address this requirement. Member Handbook addresses this requirement.	
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on 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;		Full	P/P CC.ELIG.09.01, PCP Change: CRM to Amisys Work Process addresses this requirement. P/P KY.ELIG.04 meets this requirement. Plan provided copies of letters regarding notification to member. Member Handbook addresses this requirement. Provider Manual also addresses this requirement.	

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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	P/P CC.CM.01, Case Management Program Description addresses this requirement. Member Handbook addresses this requirement. Provider Manual addresses this requirement.	
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;		Full	KY.QI.20, EPSDT addresses this requirement. The Member Handbook provides a section on EPSDT Services and provides the Member Services phone number if assistance is needed.	
M. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;		Minimal	P/P KY.MBRS.09 states that Member Services will serve as the primary vehicle through which members can access their health care benefits and services. The specific services as listed in the contract requirement are not included in the policy. These services are also not identified in the Member Handbook. There is reference to any special services needed but the services are not defined. **Corrective Action Plan** In accordance with the DMS/MCO contract	**MCO Response:** Policy and Member Handbook will be revised to include specific services as listed in contract requirement. **IPRO Comments:** No change in review determination.

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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**
			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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;		Minimal	P/P KY.MBRS.09 states that Member Services will serve as the primary vehicle through which members can access their health care benefits and services. The specific services as listed in the contract requirement are not included in the policy. P/P KY.UM.01.01 indicates the plan shall ensure direct access and may not restrict the choice of a qualified provider, however facilitating direct access by Member Services is not stated. Member Handbook identifies Member Services as a resource for any needed service throughout manual. The Handbook lists the following services: vision, primary dental, extractions (oral surgery not listed), prosthetics (prosthodontists not listed), women's health specialists, family planning, immunizations and treatment of HIV. The following services are not listed: orthodontists, maternity care for members under age 18, HIV testing, tuberculosis screening/evaluation/treatment, testing	**MCO Response:** Policy and Member Handbook will be revised to include specific services as listed in contract requirement. **IPRO Comments:** No change in review determination.

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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**
			for other communicable diseases. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
O. Facilitating access to behavioral health services and pharmaceutical services;		Full	The Member Handbook refers to Cenpatico with a phone number to call for facilitating access to behavioral health services. Member Services is the resource for pharmaceutical services.	
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;		Minimal	P/P KY.MBRS.09 states that Member Services will serve as the primary vehicle through which members can access their health care benefits and services. The specific services as listed in the contract requirement are not included in the policy. Member Handbook identifies Member Services as a resource for any needed service throughout manual. The specific services as listed in the contract requirement are not included in the handbook. **Corrective Action Plan**	**MCO Response:** Policy and Member Handbook will be revised to include specific services as listed in contract requirement. **IPRO Comments:** No change in review determination.

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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	P/P KY.MBRS.09 meets the requirements.	
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;		Substantial	P/P KY.MBRS.09 states that Member Services will serve as the primary vehicle through which members can access their health care benefits and services. Transportation services are not addressed in the policy. The Member Handbook addresses this requirement. **Recommendation for KY Spirit** The plan should add transportation to the policy.	**MCO Response:** Policy will be revised to include specific services as listed in contract requirement. **IPRO Comments:** No change in review determination.
S. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking		Full	P/P KY.QI.11.01, Grievance Process addresses this requirement.	

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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**
an expedited Appeal;			P/P CC.QI.17, Monitoring Quality of Care addresses monitoring of member grievances. P/P KY.MBRS.09 describes handling, recording and tracking member concerns. Member Handbook identifies Member Services as the contact to report a grievance.	
T. Facilitating access to Member Health Education Programs;		Full	P/P KY.MBRS.02 addresses this requirement. P/P KY.MBRS.09 addresses this requirement.	
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	P/P CC.CM.01.01, Health Risk Screening (HRA) Process addresses HRA. P/P KY.MBRS.09 addresses this requirement. P/P CC.CM.01 addresses case management.	
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	P/P KY.MBRS.09 addresses this requirement.	
30.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall		Substantial	Not addressed in the policies provided.	**MCO Response:** Policy will be revised to include this

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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**
not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.			Member Handbook addresses the requirement for billing of member. Provider Manual addresses this requirement, however does not indicate that the provider will be guilty of a felony. **Recommendation for KY Spirit** The MCO should include this requirement in a policy/procedure. The Provider Manual should be updated to include the requirement in its entirety.	requirement. Provider Manual will be updated to include the requirement in its entirety. **IPRO Comments:** No change in review determination.
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.		Substantial	Not addressed in the policies provided. Provider Manual addresses this requirement. Member Handbook addresses this requirement. **Recommendation for KY Spirit** The MCO should include this requirement in a policy/procedure.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.
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.		Substantial	P/P KY.ELIG.04 addresses this requirement regarding non-dual members. P/P KY ELIG.03 addresses this requirement for non-dual members.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.

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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**
			P/Ps provided do not address disabled children or foster care children. **Recommendation for KY Spirit** The plan should include disabled and foster care children in the policies or create separate policies.	
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	P/P KY.ELIG.04 addresses this requirement. P/P KY ELIG.03 addresses this requirement.	
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.		Full	P/P KY ELIG.03 addresses this requirement. P/P KY.ELIG.04 addresses this requirement. Member Handbook addresses this requirement.	
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.		Minimal	P/P KY.ELIG.04 addresses this requirement, however there is no reference to the 10 days as specified in the requirement. P/P KY ELIG.03 addresses this requirement, however there is no reference to the 10 days as specified in the requirement. The Member Handbook also does not specify the 10 day timeframe.	**MCO Response:** Policy will be updated to include requirements as explained in the previous column. **IPRO Comments:** No change in review determination.

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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**
			Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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.		Minimal	P/P KY ELIG.03 does describe that a member may change PCPs but does not include all the circumstances included in the requirement. The Member Handbook does indicate how to change your PCP, however the specific rights as written are not provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy and Member Handbook will be revised to include this requirement. **IPRO Comments:** No change in review determination.
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		Minimal	P/P KY ELIG.03 addresses the member's ability to change PCPs but does not address causes.	**MCO Response:** Policy and Member Handbook will be revised to include this requirement. **IPRO Comments:** No change in review

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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**
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.			The Member Handbook indicates an ability to change PCPs, but does not indicate the causes and time frame as written in the requirement. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	determination.
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.		Minimal	Not addressed in policies provided. The Member Handbook did address this requirement. The Provider Manual did not address this requirement. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy and Provider Manual will be revised to include this requirement. **IPRO Comments:** No change in review determination.
PCPs shall not have the right to request a Member's		Non-Compliance	Not addressed in policies provided.	**MCO Response:** A policy will be created to address

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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**
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.			**Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Member Disenrollment by a PCP. **IPRO Comments:** No change in review determination.
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.		Minimal	P/P KY.UM.24, Continuity and Coordination of Services addresses initial provider serving until new provider begins. Policies provided did not address provider request for change or the member's right to appeal such a request. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** A policy will be created to address Member Disenrollment by a PCP. **IPRO Comments:** No change in review determination.
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.		Non-Compliance	Not addressed in policies provided. **Corrective Action Plan** In accordance with the DMS/MCO contract	**MCO Response:** CC.MBRS.27, KY.PRVR.05 and KY.PRVR.23 along with all applicable attachments are provided. These are specific to the voluntary or involuntary termination of a PCP. The policies will be

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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**
			(provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	reviewed to check accuracy and compliance with the contractual requirements. Any appropriate changes will be made. **IPRO Comments:** No change in review determination.
30.5 Referral for Non-covered Contractor Services				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the contract, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Member for Non-Covered services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.		Full	P/P KY.CONT.03, Single Case Agreements addresses this requirement. P/P KY.CONT.01, Network Adequacy addresses this requirement	

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Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	30	44	8	4
Total Points	90	88	8	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**186/86=2.16**		

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

Enrollee Rights and Protection: Enrollee Rights
Suggested Evidence

Documents

Policies/Procedures for:

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

Member Handbook including any separate inserts or materials
Sample Member newsletters and other informational materials
Sample Provider newsletters and other informational materials
Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers
Sample of member notifications of voluntary and involuntary PCP termination
Evidence of provision of Member Handbook within five business days of notification of enrollment

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics
Medical call-in system metrics

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

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Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.		Full	P/P CC.Conn.01, Member Connections Program Description states that among many services, the MCO also provides outreach to members to best utilize services and benefits, maintains accurate logs of all outreach activities and member contacts, and arranges and hosts educational programs. KY Spirit provided an Annual Outreach Plan for 2012 with a Quarterly Activity Summary which included quarterly reports of listed quality improvement activities that addressed education and outreach programs to members, elected officials, plan members, and community organizations. Services and benefits were addressed. This report indicates that Member Connection Representatives and Member Connections Manager are the MCO staff responsible for these programs with quarterly monitoring. Monthly reports were also submitted that met all requirements. P/P KY.MBRS.02 describes that all educational material will be geared towards a 6th grade level and comply with the Americans with Disabilities Act of 1990 with Braille and audio tapes available, telecommunication devices and Spanish translations.	

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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**
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	KY Spirit submitted an Annual Outreach Plan for 2012 that included education of pregnant members at the Lexington County Health Department, a public library and the Warren County Health Department, a regional FRYSC statewide meeting addressing EPSDT and MCO awareness at multiple meetings throughout the first through third quarters, diabetes awareness education of elected officials, awareness of issues facing children for education of elected officials with a Foster Care Liaison representing the Plan, Statewide Health Fairs throughout the year, Healthy Children community event at a KY Psychological Convention, Celebrate the Child community event at the Ohio County High School, Walk for Babies/March of Dimes, Walk for Diabetes, Back to School Bash at various county locations as a community outreach to support schools in areas, and many community events for mental health, public health and early childhood education. Monthly reports met all state contract requirements.	
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 for 2012 includes frequency of activities, staff person responsible and documentation of activities. Monthly reports submitted for 2012 addressed all state requirements.	
22.4 Outreach to Homeless Persons				

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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**
The Contractor shall assess the homeless population within the Contractor's Region and by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.		Substantial	A separate outreach plan for the homeless population was not provided. KY Spirit submitted third and fourth quarter reports for 2012 titled Homeless Outreach Plan. These reports included efforts to identify facilities and programs in the regions the plan serves. Outreach visits and education were provided to homeless groups including victims of domestic violence. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** KSHP submitted an Outreach Plan that included outreach to the Homeless Persons population and victims of domestic violence. Please see attached Outreach Plan. With the above clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** Review determination changed to Substantial. Outreach Plan includes activity related to homeless population. Information provided in the quarterly reports is more detailed and targeted, and these activities should be included in the Outreach Plan.
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.		Substantial	A separate outreach plan for the homeless population was not provided. The third and fourth quarter reports for 2012 Homeless Outreach Plan included utilizing community resources to such as shelters and clinics, as well as face to face encounters which included events specifically addressing this population such as free flu shots to members. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written	**MCO Response:** KSHP submitted an Outreach Plan that included outreach to the Homeless Persons population and victims of domestic violence. Please see attached Outreach Plan. With the above clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** Review determination changed to Substantial. Outreach Plan includes activity related to homeless population. Information provided in the quarterly reports is more detailed

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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**
			corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	and targeted, and these activities should be included in the Outreach Plan.
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.		Non-Compliance	There is no policy or plan submitted that addressed transportation services for the homeless or victims of domestic violence. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** As stated in the contract: Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable. However, the wording states May provide, not Will provide. With the above clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination. Transportation services for these populations are not addressed in policies or Outreach Plan. The term "may" refers to different methods of providing assistance, such as bus tokens.
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	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
be published in at least a 14-point font size, and		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	

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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**
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
Font size requirements shall not apply to Member Identification Cards.		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
Braille and audiotapes shall be available for the partially blind and blind.		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
Provisions to review written materials for the illiterate shall be available.		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
Telecommunication devices for the deaf shall be available.		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.		Full	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.		Substantial	P/PKY.MBRS.25, Members Rights and Responsibilities indicates that any changes will result in notification of members through a newsletter, member handbook or the KY Spirit website. The policy does not address how the member may obtain an updated list of participating providers. The Member Handbook provides information on how to obtain an updated list of providers by calling Member Services or accessing the plan's website. **Recommendation for KY Spirit** The MCO should add this requirement to P/P KY.MBRS.02.	**MCO Response:** Policy will be updated to add requirement. **IPRO Comments:** No change in review determination.

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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**
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	Addressed in P/P KY.MBRS.02, Member Materials Readability and Translation.	
28.12 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.		Non-Compliance	P/P KY.Members.25 addresses non-discrimination. This policy does not address cultural consideration and competency. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** Policy will be updated to include cultural consideration and competency. KY.MBRS.09 has a section (Call Center Availability and Staffing, Part D) that speaks to Member Services Representatives being thoroughly trained in Cultural Competency. **IPRO Comments:** No change in review determination.
The Contractor shall communicate such policies to Subcontractors.		Full	Documentation provided did not address this requirement. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an	**MCO Response:** Subcontractors to include both delegated vendors and providers have signed contracts that include: 3.7 Cultural Consideration and Competency. Provider shall deliver Covered Services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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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**
			adverse quality finding or deficiency identified by the EQRO.	Contract examples were included in original submission materials and actual contracts for all 7 vendors were submitted. With the above clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** Review determination changed to Full. Subcontractor agreements include this requirement.

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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	13	3	0	2
Total Points	39	6	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**45/18=2.5**		

Reviewer Decision:

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

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Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

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

Reports

Reports of outreach activities

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

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Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
38.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.		Full	Medical records are not maintained by the contractor. KY Spirit has policies and procedures in place for its providers' medical records.	
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.		Full	P/Ps related to confidentiality include: CC.COMP.PRVC.09, Privacy Notice – Content of Notice CC.COMP.PRVC.01, HIPAA Required Policies and Procedures and Record Retention CC.COMP.PRVC.17, Individual Rights Regarding Protected Health Information.	
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.		Non-Compliance	KY Spirit did not provide documentation of HIPAA privacy and security audits of its providers.	**MCO Response:** The Plan has not been provided any guidance from DMS that defines the scope, frequency, or method for which to conduct the privacy and security audit.

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	With the above clarification, the Plan requests that IPRO that this element be revised to reflect Non-applicable or full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
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.		Substantial	KY Spirit's subcontracts contain provisions for access to member medical records and other records by the MCO, Department, OIG, and other authorized Commonwealth and Federal Agents. The provisions for transfer of member medical records to the PCP or MCO were not addressed in the documents provided. The Provider Manual notes that providers must document efforts to obtain transferred records; and providers must transfer records to members' new provider upon request. No timeframes were included. **Recommendation for KY Spirit** KY Spirit should revise its Provider Manual to include the MCO contract requirements for transfer of records.	**MCO Response:** Provider Contract - 6.5. Record Transfer specifies a Provider is subject to applicable law and Payor Contract requirements, and that a Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider at no charge and when required. Payor Contract is defined referencing contract between KSHP and State. Provider Manual will be updated to expand policy for transfer of member medical records. **IPRO Comments:** No change in review determination.
The Contractor shall have a process to systematically review provider medical		Full	Addressed in P/P KY.QI.13, Medical Record Review, which includes the procedures and	

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.			the audit tool. Improvement actions and assessment of effectiveness of improvement actions are not applicable since KY Spirit has not yet conducted a medical record audit.	
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	KY Spirit has not yet conducted its first medical record audit (CY 2012). Assessment of compliance for PCPs and high volume/high risk specialties is addressed in P/P KY.QI.13. The dental vendor contract indicates that the dental vendor must conduct oversight of its dental providers' record keeping practices. No documentation was found related to monitoring of medical record keeping for ancillary providers. Cenpatico monitors the medical record keeping of behavioral health providers. **Recommendation for KY Spirit** KY Spirit should develop medical records keeping standards and methodology for high	**MCO Response:** P/P KY.QI.13 has been revised to include ancillary providers. The P/P includes the following language: "The Plan will perform the record review and will assess 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. Revised P/P KY.QI.13 is attached for review. With the above revision to the policy, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			volume/high risk specialists (other than OB/GYNs) and ancillary providers, or require its subcontractors to do so where applicable.	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;		Full	KY Spirit indicated that audit of compliance with clinical practice guidelines would be conducted as part of the first data collection for HEDIS reporting (HEDIS 2013 for CY 2012). Indicators for review of preventive care guidelines are incorporated in the review for medical record keeping standards. KY Spirit indicated that the HEDIS indicators are used, where applicable, to assess provider compliance with clinical practice guidelines (e.g., care of diabetes, asthma).	
B. Allow for the tracking and trending of individual and plan wide provider performance over time;		NA	KY Spirit has not yet conducted a review of compliance medical record standards. Review for CY 2012 is being conducted as part of HEDIS 2013 data collection.	
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and		Full	Addressed in Provider Manual.	
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.		Full	Addressed in Provider Manual.	
27.6 Medical Records				

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The 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	Addressed in Provider Manual.	
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 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		Non-Compliance	P/P CC.COMP.PRV.17 describes the policies and procedures related to member access to records. The policy is not compliant with the Contract standard that members are "entitled to one free copy of his/her medical record" as it indicates members may be charged reasonable costs/fees for copying, postage, and preparation of an explanation/ summary. The policy does not address cost for additional copies. Retention of Immunization and tuberculosis	**MCO Response:** Policy will be revised to reflect the contract requirements. Please note the current policy specifies "may" versus "shall" and KSHP does provide for one free copy. Contract specifies: Additional copies shall be made available to Members at cost. P&P CC.COMP.PRV.17. Addresses cost as follows: 15. 15. Any fees imposed on the member for a copy of the protected health information or a summary or explanation of such information will: (a)be collected by the Health Plan Privacy Official

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
kept for a person's lifetime).			records (required to be kept for a person's lifetime) is not addressed in the P/Ps provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	or their designee at the time of receipt of the request and the proper completion of the request form; (b)be reasonable and cost-based; and (c)be only for the cost of the following: (1)Copying, including the cost of supplies for and labor of copying, the protected health information requested by the member; (2)Postage, when the member has requested the copy, or the summary or explanation, be mailed; and (3)Preparing an explanation or summary of the protected health information. With the above clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
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	Addressed in P/P KY.QI.13.	
A. Member/patient identification		Full	Addressed in Provider Manual and the	

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
information, on each page;			medical record review tool.	
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;		Substantial	Race/Ethnicity was not addressed in documents provided. **Recommendation for KY Spirit** The MCO should add documentation of race/ethnicity to its medical record standards and the medical record review tool.	**MCO Response:** KY.QI.13 The Medical Record Review tool has been revised to include Race/Ethnicity. With the above revision, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
C. Date of data entry and date of encounter;		Full	Addressed in the Provider Manual and the medical record review tool.	
D. Provider identification by name;		Full	Addressed in the Provider Manual and the medical record review tool.	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;		Full	Addressed in the Provider Manual and the medical record review tool.	
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	Addressed in the Provider Manual and the medical record review tool, however both indicate that this is required for "FOR PATIENTS SEEN THREE (3) OR MORE TIMES ONLY." **Recommendation for KY Spirit** KY Spirit should revise these documents to comply with the contract requirement.	**MCO Response:** KY.QI.13 indicates that for sampling purposes the files requested will be: "For OB/GYN specialists a list of members who have accessed care with the specialist at least 3 times within the designated time frame will be requested for random selection." This requirement was not stated for any other provider type and the statement has been removed from the policy. With the above policy revision, the Plan requests

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
				that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
G. Identification of current problems;		Full	Addressed in the Provider Manual and the medical record review tool.	
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	Addressed in the Provider Manual and the medical record review tool.	
I. Documentation of immunizations pursuant to 902 KAR 2:060;		Full	Addressed in the Provider Manual and the medical record review tool.	
J. Identification and history of nicotine, alcohol use or substance abuse;		Substantial	Addressed in the Provider Manual and the medical record review tool, however both indicate that this is for "FOR PATIENTS SEEN THREE (3) OR MORE TIMES." Also there is an age parameter that is not consistent between the two documents. **Recommendation for KY Spirit** The MCO should eliminate the condition related to a minimum number of visits, and ensure consistency in the requirements stated in each document.	**MCO Response:** "FOR PATIENTS SEEN THREE (3) OR MORE TIMES." Was addressed in a previous section of this document and has been corrected in KY.QI.13. KY.QI.13 has also been changed to age 10 to provide consistency among documents. With the above revision, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
K. Documentation of reportable diseases and conditions to the local health		Substantial	Documentation of reportable diseases/ conditions (902 KAR 2:020) appears in the	**MCO Response:** Provider Manual will be revised to include this requirement.

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;			medical record review tool, but not in the Provider Manual. **Recommendation for KY Spirit** Provider Manual should be revised to include this requirement.	**IPRO Comments:** No change in review determination.
L. Follow-up visits provided secondary to reports of emergency room care;		Substantial	Addressed in the medical record review tool but not in the Provider Manual. **Recommendation for KY Spirit** Provider Manual should be revised to include this requirement.	**MCO Response:** Provider Manual shall be revised to include this requirement. **IPRO Comments:** No change in review determination.
M. Hospital discharge summaries;		Full	Not addressed in documents provided. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	**MCO Response:** The Medical Record Tool has the following area of assessment listed: "Hospital discharge summaries, consultation, lab and imaging reports filed in the chart and initialed by the practitioner who ordered them to signify review. The provider manual states: "Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries," Based on the above documentation, that is contained in the P/P KY.QI.13 and the Provider Manual presented to the IPRO at on-site review, With the above revision, the Plan requests that

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** Review determination changed to Full. Addressed in policy and tool.
N. Advanced Medical Directives, for adults;		Full	Addressed in Provider Manual and medical record review tool.	
O. All written denials of service and the reason for the denial; and		Substantial	Addressed in the medical record review tool but not in the Provider Manual. **Recommendation for KY Spirit** Provider Manual should be revised to include this requirement.	**MCO Response:** Provider Manual will be revised to include this requirement. **IPRO Comments:** No change in review determination.
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	Addressed in the Provider Manual and the medical record review tool.	
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;		Substantial	Addressed in the Provider Manual and the medical record review tool, however reference to relevant psychological and social conditions was not found. **Recommendation for KY Spirit** KY Spirit should revise the documents to be consistent with the contract requirements.	**MCO Response:** P/P KY.QI.13 Medical Record Tool has been revised as follows and is attached: "including relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;" Provider Manual will be revised to include this

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				requirement. **IPRO Comments:** No change in review determination.
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		Substantial	The Provider Manual and the medical record review tool only address abnormal results from prior visits. All results should be addressed. **Recommendations for KY Spirit** KY Spirit should revise the documents to be consistent with the contract requirements.	**MCO Response:** P/P KY.QI.13 Medical Record Tool has been revised as follows and is attached: "Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits;" Provider Manual will be revised to include this requirement. **IPRO Comments:** No change in review determination.
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.		Substantial	Addressed in the medical record review tool. The Provider Manual does not include medication history and only refers to "instructions for medications". All components should be addressed in the Provider Manual. **Recommendation for KY Spirit** The Provider Manual should be revised to address this requirement.	**MCO Response:** Provider Manual will be revised to include this requirement. **IPRO Comments:** No change in review determination.
27.7 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives		Full	Addressed in P/P KY.CM.10, Advance Directives.	

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.				
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.		Substantial	No evidence/documentation of training for Member Services staff. Addressed in Member Handbook, Welcome Kit, Provider Manual and P/P KY.CM.10. **Recommendation for KY Spirit** The MCO should provide and document training for Member Services staff on Advance Medical Directives.	**MCO Response:** All documents will be revised as recommended. Member Services staff training will be reviewed and redeployed as recommended. **IPRO Comments:** No change in review determination.
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.		Full	Addressed in the Provider Manual	
38.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection		Full	P/P CC.COMP.PRVC.09 and P/P CC.COMP.PRVC.01 address requirement.	

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.				
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.		Substantial	P/P CC.COMP.PRVC.09 and P/P CC.COMP.PRVC.01 provided for review. The following provisions were not addressed in the documents reviewed: ▪ Assuring confidentiality of services for minors for diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth ▪ How to contact the minor Member for follow-up and limitations on telephone or mail contact to the home. **Recommendation for KY Spirit** The MCO should add the provisions to its current P/Ps or create a separate P/P to address these requirements.	**MCO Response:** P/P will be revised to reflect the recommendations. **IPRO Comments:** No change in review determination.
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.		Non-Compliance	Not addressed in the documentation provided.	**MCO Response:** Please refer to the contract with DMS, Appendix P, under Business Associates Agreement. Within this documentation, this

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Corrective Action Plan In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	ensures contractor, employees, agents and assigns, are subject to and have executed a confidentiality agreement. With the above clarification, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.		Full	Addressed in P/Ps CC.COMP.PRVC.09 and CC.COMP.PRVC.01.	
40.12 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health		Full	Addressed in subcontractor agreement.	

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State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as is the Contractor.				

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Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	23	13	0	3
Total Points	69	26	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		**95/39=2.44**		

Reviewer Decision:

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

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Medical Records
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Provider compliance assessment/monitoring results and follow-up

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

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.3 General Behavioral Health Requirements				
The Department requires the Contractor's provision of 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	The focus of Cenpatico's BH program is delineated in P/P CCC.001, Clinical Program Description.	
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	Provision of medically necessary services is addressed in P/P CCC.001 Clinical Program Description.	
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV.		Full	Access to BH services in conformance with KY-specific standards is addressed in P/P CQI.103 Quality Improvement Evaluation of the Accessibility of Services, the 2012 Network Access Report, and Appointment Availability standards/assessment. Cenpatico met all benchmarks except that for inpatient BH services. (1:1,000 vs. the required 0.23:1,000). In order to address this, Cenpatico implements single-case agreements with non-par facilities when necessary. Use of the DSM IV classification is stated in P/P CCC.001 Clinical Program	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Description.	
Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.		Full	The requirement for providers to use DSM IV classification is presented in P/P CCC.001 Clinical Program Description.	
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 assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.		Full	Utilization Management for medically necessary BH services is addressed in P/P CCC.001 Clinical Program Description, CQI.103 Quality Improvement Evaluation of Accessibility of Services, and CQI.103.01 Appointment Access Audits.	
The Contractor shall utilize DSM-IV classification for Behavioral Health billings.		Full	Addressed in the Provider Manual.	
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.		Full	Inclusion of the required provider types was evidenced in the Network Access Report 2012, P/P CCC.001 Clinical Program Description.	
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	Inclusion of CMHCs in the network was demonstrated in the Network Access Reports 2012 and by CMHC contracts.	
Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.		Full	P/P CNM.409 describes inclusion of providers with experience serving children and adolescents, persons with disabilities, the elderly, and cultural and linguistic minorities in the network.	

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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**
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	Ensuring accessibility and availability of qualified providers in all service areas is demonstrated in the Network Access Report 2012. Cenpatico executes single-case agreements with non-par providers to address the need for inpatient BH facilities where necessary.	
To the extent that non-psychiatrists and other providers of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.		Full	FQHCs are included in Cenpatico's network as demonstrated in the Network Access Report 2012 and FHQ contracts.	
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	Community Mental Health Centers participate in Cenpatico's network.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.		Full	Members are informed how to access BH Services via the Kentucky Spirit Member Handbook, KY Spirit Member Welcome Packet, KY Spirit 24 Hour Nurse Line.	

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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**
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	Member selection of an appropriate BH providers and connecting members to available BH services is addressed in P/P CCL.204.FC.KY Case Management and Care Coordination.	
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Contractor's region.		Full	Emergency and Crisis Hotline is addressed in P/Ps CCS.423 CSR Quality Monitoring - Cenpatico, CCS.412 Cenpatico Hotline Performance Standards, CCL.207 Call Center Hours, CCL.244 Emergency Services. The BH Hotline is available via a prompt on the KY Spirit Nurse Line.	
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.		Full	Access to qualified BH professionals via the Hotline is addressed in CCL.207 Call Center Hours and CCL.209 Assessment and Referral of Crisis Calls. In addition, Cenpatico staff stated that the UM Supervisor and BH Medical Director are available.	
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	P/P CCL.207 Emergency Services addresses 24 hour, 7-Day face-to-face emergency services for BH.	
It is not acceptable for an intake line to be answered by an answering machine.		Full	According to Cenpatico, the Hotline is never attended by an answering machine, per P/P CCL.244 Emergency Services and CCL.207 Call Center Hours.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:		Full	Monitoring the Hotline is addressed in P/Ps CCS.423 CSR Quality Monitoring Cenpatico, CCS.412 Cenpatico Hotline Performance Standards. Cenpatico provided reports of monthly monitoring.	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;		Full	Cenpatico provided reports of monthly monitoring that demonstrated compliance with this standard.	
B. No incoming calls receive a busy signal;		Full	Cenpatico provided reports of monthly monitoring that demonstrated compliance with this standard.	
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;		Full	Cenpatico provided reports of monthly monitoring that demonstrated compliance with this standard.	
D. The call abandonment rate is seven percent (7%) or less;		Full	Cenpatico provided reports of monthly monitoring that demonstrated compliance with this standard.	
E. The average hold time is two (2) minutes or less; and		Full	Cenpatico provided reports of monthly monitoring that demonstrated compliance with this standard, with one month outside of parameters.	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.		Full	Cenpatico indicated that the Hotline staff is able to access local Suicide Hotlines, Crisis Response Systems, and 911 per P/P CCL.209 Assessment and Referral of Crisis Calls. A nurse/BH	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			clinician is on call at all times.	
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.		Full	P/P CCL.207 Emergency Services delineates the policies for operation of the Hotline. There is a dedicated line for the Hotline and staff is assigned to incoming calls based on their area of expertise (KY, other state(s)). Cenpatico reported a 'blockage rate' (member gets a busy signal) as < 1%.	
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.		Full	Cenpatico indicated that there is not a specific call duration limit. Average time ranged from 3:32 to 4:26 in 2012. Staff is encouraged to 'control' calls so that adequate, accurate assistance is provided.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.		Full	The Provider Manual outlines the cultural and linguistic standards for the MBHO. Cenpatico reported a total of 11 calls from Spanish-speaking members in 2012.	
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.		Full	P/P CCL.207 delineates the policies for operation of the Hotline. P/P CCS.423 CSR Quality Monitoring defines the business knowledge program knowledge for Hotline staff. There is a dedicated line for the Hotline and staff is assigned to incoming calls based on their area of expertise (KY, other states).	

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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**
The Contractor shall conduct on-going quality assurance to ensure these standards are met.		Full	P/P CCS.412 Cenpatico Hotline Performance Standards - Cenpatico demonstrated its quality monitoring for the Hotline with multiple monthly reports for a variety of call center metrics.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.		Full	Cenpatico demonstrated its performance against the standards with multiple monthly reports for a variety of call center metrics.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.		NA	Cenpatico reported no monitoring visits in 2012.	
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.		Full	The Provider contract and the Provider Manual, Provider Rights and Responsibilities includes the requirement for PCP screening, evaluation, and treatment of BH conditions.	
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		Non-Compliance	Trainings for PCPs are described in P/P CCL.001 Clinical Program Description and CCL.204 Coordination with Medical Services. Cenpatico also includes in the Provider Manual that Cenpatico will	**MCO Response:** PCP training information on nine (9) specific behavioral health topics has been created and submitted for expedited approval from Kentucky Spirit and the State. Upon approval of

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.			provide at least annually, training for KY Spirit and PCP providers. However, PCP training was not conducted in 2012. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	Health Plan and State training documents can be submitted to PCPs, via Kentucky Spirit Health Plan. Cenpatico and Kentucky Spirit Health Plan have agreed to include PCP training collaboration as a standing agenda item on the regularly scheduled Vendor Oversight meetings. This will ensure regular collaboration and scheduling of PCP trainings, related to behavioral health topics, on an ongoing basis. With submission of additional clarification and documentation, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
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	P/P CCL.204 Coordination with Medical Services and CCL.401 Case Management outline the procedures for coordination of BH and physical health (PH) services.	
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.		Full	P/P CCL.401 Case Management describes the process for case managers to refer members for treatment of physical health problems. The Cenpatico Provider Manual states that BH providers are required to refer	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
This requirement shall be specified in all Provider Manuals.			members with PH problems to their PCP for exam and treatment. The Manual states that BH providers may only provide services within the scope of their license.	
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.		Substantial	Cenpatico's BH provider contracts require that initial and quarterly reports be sent to the member's PCP. P/P CCL.204 states that BH providers are encouraged to send initial and quarterly reports to the member's PCP. The Provider Manual states that BH providers are encouraged to send initial and quarterly reports to the member's PCP. **Recommendation for KY Spirit** Cenpatico should revise the wording in P/P CCl.204 to comply with this requirement.	**MCO Response:** P&P CCL.204 has been updated. Draft form included for submission. With submission of additional documentation, the Plan requests that this element be revised to reflect full compliance. **IPRO Comments:** No change in review determination.
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	P/P CCC.001 Clinical Program Description, the BH provider/facility contracts, and the contract Attachment A include the requirement that members are scheduled for outpatient follow-up/continuing treatment prior to discharge.	
The outpatient treatment must occur within fourteen		Full	P/P CCL.212 Care Coordination includes	

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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**
(14) days from the date of discharge.			the requirement that members receive follow-up care after inpatient BH admission within 7 days of discharge (more stringent than the KY contract standard).	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.		Full	The Provider Manual delineates the requirement that BH providers follow-up with members who have missed an appointment within 24 hours.	
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	P/P CCL.706 Medicaid Covered Services indicates that inpatient psychiatric services will be provided, up to the annual limit, to members ≤ age 21 and ≥ age 65 who have been ordered to receive the service by a court.	
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	P/P CCL.706 Medicaid Covered Services states that there will be no denials for court-ordered inpatient services for members ≤ age 21 and ≥ age 65.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.10 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	P/P 706.KY Collaboration Agreement, BH provider/facility contract and Attachment A coordination with the CMHCs and/or other qualified specialty, and behavioral health providers, state psychiatric hospitals, and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for members with court-ordered inpatient admissions.	
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	Cenpatico maintains provider/facility contracts and Collaboration Agreements with state hospitals that include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.	
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.		Full	Cenpatico provided meeting minutes for quarterly coordination of care meetings.	
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide case management services to Members with severe mental illness and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or		Full	The BH provider/facility contract and Collaboration Agreement, P/P CCC.001 Clinical Program Description, and CCL.219 Standards for Discharge Planning state that a case manager is assigned prior to/at discharge and	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
state operated nursing facility for Members with severe mental illness.			provides case management services to members with severe mental illness and co-occurring developmental disabilities who are discharged from a state psychiatric or nursing facilities.	
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.		Full	Cenpatico provided State hospital case meeting minutes to demonstrate that case managers and BH service providers participate in discharge planning meetings in accordance with the federal Olmstead/other applicable laws. Cenpatico's P/P CCL.207 Case Management Assistance and CCL.219 Standards for Discharge Planning outline the standards and procedures for discharge planning.	
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	Cenpatico ensures follow-up and support post discharge is required per P/P CCL.207 Case Management Assistance.	
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	The BH provider/facility contract and Collaboration Agreement require that members receive assistance in accessing free/ discounted medication through KPAP/other similar programs.	
33.11 Program and Standards				
Appropriate information sharing and careful monitoring				

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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	Guidelines/procedures and monitoring to ensure accessibility, availability, referral and triage and emergency BH services are outlined in CQI.103.01 Appointment Access Audits, CQI.103 QI Evaluation Access Services, Network Access Reports 2012, CMM.405 Network Adequacy, CMM.401 Appointment Access Standards, CCL.244 Emergency Services.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;		Full	CCL.227 Procedures for Pharmaceutical Management, CCL.204 Coordination with Medical Services describe the exchange of information among providers to reduce inappropriate/excessive use of psychopharmacological medications and adverse drug reactions.	
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;		Minimal	Cenpatico indicated that BH providers are asked about PCP coordination with all outpatient treatment authorizations. Cenpatico indicated that annually, data is collected and analyzed regarding coordination of care. No reports for	**MCO Response:** The Cenpatico process for evaluating and monitoring coordination of care is outlined in the Cenpatico QI Program Description and Cenpatico QI Evaluation. Please see enclosed, annotated documents and reports.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			2012 were found and this activity was not seen in the QI Work Plan. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	With submission of additional clarification and documentation, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
D. Protect the confidentiality of Member information and records; and		Full	Member confidentiality policies and procedures include: CCL.001 Clinical Program Description, CC.COMP.04 Confidentiality and Release of Protected Health Information, and the Provider Manual.	
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.		Non-Compliance	Evidence of monitoring and evaluation of member confidentiality was not found in the QI Work Plan and no reports were found. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO	**MCO Response:** Cenpatico Compliance conducts annual mandatory HIPAA training for all employees as well as quarterly desk audits where each desk is reviewed on a non-disclosed date at the end of a work day. Any employee who has a HIPAA infraction and their supervisor is notified and given additional training. Additionally, there have been four (4) HIPAA disclosures of faxed data that were corrected shortly after the breach and the responsible employee was

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	retrained. Several HIPAA Compliance P&Ps are also enclosed. With submission of additional documentation, the Plan requests that this element be revised to reflect full compliance and the removal of the CAP Requirement. **IPRO Comments:** No change in review determination.
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.		NA	DMS responsibility.	

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

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Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	49	1	1	2
Total Points	147	2	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		**150/53=2.83**		

Reviewer Decision:

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

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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

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

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
31.1 Pharmacy Requirements				
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;		Full	Addressed in the following documents: Drug Utilization Review CC.PHAR.04 US Script Description of Pharmacy Benefit Management Services USS.Admin.01 Kentucky Spirit Claim Reconsideration/ Disputes & Appeals KY.CLMS.10.76 Pharmacy Program CC.Pharm.09 policy	
B. Retrospective utilization review services;		Full	Addressed in Pharmacy Program CC.Pharm.09 policy and Drug Utilization Review CC.PHAR.04.	
C. Formulary and non-formulary services, including prior authorization services;		Minimal	MCO Report #39 for the time period of December 2011-December 2012 shows a large number of prior authorizations (PA) at nearly 1:1 per claim, yet most are not denied: Total Prescriptions (new & refill)= 2,241,733	**MCO Response:** None

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Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Total #claims =2,453,468 Total #PAs =2,453,388 Total #PAs denied = 1,936. High numbers of PA's and low denials are also shown on MCO Reports 59 for review period. The impact of high numbers of PAs on members does not appear to be measured (i.e. potential delays in care/receipt of prescription therapy). MCO Report # 45B (Q4 2012) Top 50 Non-PDL Drugs by Reimbursement shows 28 of 50 drugs are generics. Of these 28, 25 are antibiotics and 3 are antihypertensives. Review of this report and the PDL indicates that restrictions on commonly utilized antibiotics are excessive. The impact of these restrictions on members does not appear to be measured (i.e. potential delays in care/receipt of prescription therapy). (PDL=Preferred Drug List) **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to	

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere; and		Full	Addressed in Kentucky Spirit Health Plan – Benefit Summary and US Script Description of Pharmacy Benefit Management Services USS.Admin.01	
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors.		Full	Addressed in US Script Description of Pharmacy Benefit Management Services USS.Admin.01.	
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.		Minimal	Information is made available to pharmacy providers and members regarding PDL and co-pays, etc. however the process for ensuring this availability is found in a free-standing undated document entitled, "Process for informing members and pharmacy providers of PDL and related information". This process should be documented in policy and procedure format. Likewise, the process for evaluating the impact of the program on members is found in a free-standing undated document. The policy, Lock-In	**MCO Response:** None

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Program KY.CM.04 addresses member overutilization of services. There appears to be no policy that addresses program impact on members. MCO Report #39 For the time period of December 2011-December 2012, KY Spirit reported 2,241,733 prescriptions. There were 312,114 non-PDL prescriptions and 2,453,388 prior authorizations (PA) requested of which .08% of PAs were denied. From the data provided it is unclear as to how many PAs were for step therapy, clinical issues or straight non-formulary items. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The committee shall meet		Substantial	Although the dates of the P&T committee meetings are announced on the website,	**MCO Response:** None

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary.			no specific invitation for public participation is apparent. Policies and procedures do not address KY law allowing public participation in P&T committee meetings. Pharmacy Program CC.Pharm.09 policy and P&T meeting minutes provided. **Recommendation for KY Spirit** The MCO should ensure that public input is sought as required by KY law.	
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.		Full	Addressed in Kentucky Spirit Health Plan PROVIDER Preferred Drug List 2012, Updating and Maintaining Formularies on US Script Website USS.COMM/MKG.04 and http://www.kentuckyspirithealth.com/for-providers/pharmacy-program/.	
31.3 Pharmacy Claims Administration				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. The Contractor shall be responsible for processing components required for paper Claims.		Substantial	Paper or manual claims are only partially addressed within policy Coordination of Benefits (COB)/Third Party Liability/Subrogation (TPL) KY.CLMS.02. The processing components are not identified within this limited policy, such as how to submit paper claims and how they are internally processed.	**MCO Response:** None

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for KY Spirit Policies should address submission and processing of paper claims.	
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.		Substantial	Paper or manual claims are only partially addressed within policy Coordination of Benefits (COB)/Third Party Liability/Subrogation (TPL) KY.CLMS.02. The processing components are not identified within this limited policy. **Recommendation for KY Spirit** Policies should address submission and processing of paper claims.	**MCO Response:** None
The Contractor shall interface with the Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.		Full	Addressed in US Script Description of Pharmacy Benefit Management Services USS.Admin.01.	
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		Non-Compliance	P/P Rebates USS.FIN.07 does not address CMS level rebates. **Corrective Action Plan** In accordance with the DMS/MCO contract (provision 21.5, EQR Performance), the MCO is required to	**MCO Response:** None

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.			submit a written corrective action plan to the EQRO and DMS within 60 days that addresses the measures the MCO intends to take to resolve an adverse quality finding or deficiency identified by the EQRO.	
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	Addressed in Drug Utilization Review Policy CC.Pharm.05 and Drug Utilization Review CC.Pharm.04. The following DUR reports were provided for the audit period: 106, 39, 59, 40A, 40B, 41, 42A, 42B, 42C, 43, 44, 45A and 45B.	

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Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	7	3	2	1
Total Points	21	6	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		**29/13=2.23**		

Reviewer Decision:

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

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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