IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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			Includes review of MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - This requirement is addressed in the 2016 Quality Assessment Performance Improvement (QAPI) Program Description and includes: Overview, Program, Goals, Objectives, Program structure, Patient Safety, Prevention and Wellness, Structure, Committee Structure, Corporate and Regional Resources, and External Quality Programs and Committee Participation. The 2016 QAPI Program is comprised of the QAPI Program Description, Policies and Procedures, Annual QAPI Work Plan, Annual QM Evaluation, QM Activities, QM Organization Structure and Administration. The 2016 QI Program Description describes the oversight, goals and objectives, the corporate and committee structure, QM staff, corporate and regional resources, behavioral health (BH) QI, the QI Work Plan, QI Evaluation, and the role of the EQRO. Implementation of the QM Program is documented in the 2016 QAPI Work Plan/ Q4 update and the 2015 Annual Evaluation of the Quality Improvement Program.			
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	Full - This requirement is addressed in the 2016 Quality Assessment Performance Improvement (QAPI) Program Description in the Goals and Objectives section on Page 7 and in Appendix 1-Goals and Objectives.			

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arranged for by the Contractor.	This requirement is demonstrated in the 2016 QAPI Work Plan/Q4 update, the 2015 Annual Evaluation of the Quality Improvement Program, the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2016/Q4 update and the 2016 Prevention and Wellness Program/Q4 update. This is also demonstrated in the HEDIS 2016 Compliance Final Report. Specifically in the Effectiveness of Care and Access and Availability Sections.			
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - This requirement is addressed in the 2016 Quality Assessment Performance Improvement (QAPI) Program. This requirement is demonstrated in the 2016 QAPI Work Plan/Q4 update, the 2015 Annual Evaluation of the Quality Improvement Program, the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2016/Q4 update and the 2016 Prevention and Wellness Program/Q4 update.			
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 - This requirement is demonstrated in the 2016 QAPI Work Plan and the 2016 Prevention and Wellness Program under "Reason for Selection" "Topic" and "Objective" as well as the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2016. The Antidepressant Medication management (AMM) Effective Acute Phase Treatment section of the HEDIS/Healthy Kentuckians (HK)/EPSDT/Foster Work Plan 2016 demonstrates linkage of PIPs and Focus Study topics.			
The QAPI program shall be developed in	Full - The QMAC charter states: "The Member Advisory			

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collaboration with input from Members.	Committee meets quarterly. The list of the Members participating with the MAC shall be submitted to the department annually. Recruitment efforts of members and/or community advocates must be documented. Minutes are documented and summary reports are sent to the QMOC and /or SIC for review and consideration." Web-ex meeting option or conference call option is available to members. The QM Trilogy Summary discusses the incorporation of the QMAC committee into QI activities. Three sets of meeting minutes are provided 3/23/16, 6/15/16 and 9/23/16. The meeting on 3/23/16 noted the participation of 3 members, however it appears that the 6/15/16 and the 9/23/16 meetings did not have a member participant. The minutes reflect minimal or no member participation in the discussion. Aetna continues attempts to recruit members for the QMAC. The MCO has been conducting in person outreach in various regions, and employing WebEx for meetings. To solicit member input, the MCO has implemented the Service Improvement Committee, which allows multiple departments, including Appeals, to report on their interactions with members. Input is also sought from Outreach Coordinators, who are out in community working with members.			

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	The MCO further solicits member input through a post-HEDIS member survey. **Recommendation for Aetna:** Aetna should continue its efforts to recruit members for QMAC.			
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - The framework for documentation and utilization of member input is described in the QMAC charter. MCO QI activities and initiatives were reviewed and updated at QMAC quarterly meetings. This framework was demonstrated in the QMAC quarterly meeting minutes from 3/23/16, 6/15/16 and 9/23/16. Additionally it was noted in the QM Trilogy Summary QMAC 6-15-16 document under Priorities for 2016, "We are working to restructure our QMAC committee to promote greater member involvement and feedback." On site, staff reported efforts to solicit member input to the QAPI program as noted above.			
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	Full - The MCO NCQA Accreditation for Medicaid Product Line expires 8/21/17 (Date of next review is 5/30/17). This requirement was evidenced by submission of the NCQA Accreditation Status_2016 document.			
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report	Full - The following documents illustrate NCQA accreditation: NCQA Accreditation Status_2016, NCQA Health Plan Ranking, and NCQA Status Notification.			

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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) Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.				
Annually, the Contractor shall submit the QAPI program description document to the Department in accordance with a format and timeline specified by the Department, after consultation with the Contractor.	Full - The MCO submitted MCO Report #84 2016 QM Program Description to DMS in January 2016.			
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 - This requirement is addressed in the 2016 QAPI Program Description in Appendix 1-Goals, items 6, 15 and 19 and 27, which include ensuring collaboration with BH networks, improving continuity and coordination of care between BH and PCPs; Page 15- QM/UM Committee -participation of a participating BH practitioner; Page 37 –regular reporting of behavioral health metrics and regular workgroup meetings provide ongoing monitoring; a behavioral health practitioner serves as a member on the QMOC and QM/UM committees. The QM Program Description indicates that a BH practitioner will participate in the QM/UM Committee, and a review of the			

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	minutes showed that MHNet staff participated in the committee, and a network BH practitioner attended the 10/20/2016 meeting as per meeting minutes. A pediatric psychiatrist attended the 10/20/16 meeting. This requirement is demonstrated in the 2016 QAPI Work Plan/Q4 update: page 4 – Access to BH practitioners, availability of BH practitioners, BH clinical guidelines, continuity and coordination of BH/PH. QM/UM Committee meeting minutes from 2/18/16, 3/17/16 and from 1/21/16 (the actual minutes are dated 1/21/2015) address the integration of behavioral health and physical health under the "Continuity and Coordination between medical and Behavioral health." Prevention and Wellness Program 2016 champions Behavioral health wellness. The HEDIS/HK/EPSDT/Foster Work Plan 2016 includes: a Major Depression and Antidepressant Medication Management and Compliance Focus Study. The requirement is also demonstrated in the 2015 Annual Evaluation of QI Program Quality and Utilization Improvement Program Evaluation.			
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting	Full - The requirement is addressed in the 2016 QAPI Program Description on pages Appendix 1-Goals, items 6, 15 and 19 and 27: which include ensuring collaboration with BH networks,			

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from behavioral health integration into the Member's overall care.	improving continuity and coordination of care between BH provider and PCP. The requirement is addressed in the 2016 Prevention and Wellness Program: "Collaboration with Care Management and Community Outreach to improve integration, coordination & continuity between prevention and wellness and behavioral health care." Activities include Participate in Behavioral Health Performance Improvement Project and interdisciplinary workgroup meetings. The requirement is addressed in the QM/UM Committee for participation of an actively practicing, participating BH practitioner on page 22, Behavioral Health QI, and is evidenced by 10/20/16 committee meeting minutes. The requirement is also demonstrated in the 2015 Annual Evaluation of QI Program Quality and Utilization Improvement Program Evaluation: MCO proposal for a PIP, which is a behavioral health collaborative focusing on adult members with serious mental illness and improving their physical health. There is also a proposal for improving post-partum physical health, along with depression. The requirement is demonstrated in PIP topics and reports. PIPs are underway related to behavioral health- Measuring the Appropriate Use and Management of Antipsychotics for Children and Adolescents, Improving Post-Partum Care (includes Post-Partum depression and Prevention of Physical Health Risks in the SMI Population).			

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	The requirement is demonstrated in the 2016 QAPI Work Plan Row # 44: "Collaborate with behavioral healthcare practitioners to monitor and improve coordination between medical care and behavioral healthcare. Perform activities that meet regulatory requirements." Finally, the requirement is demonstrated in the 2016 Healthy Kentuckian /EPSDT/Foster care Work Plan: Antidepressant Medication Management Effective Continuation Phase Treatment Focus Study.			
The Contractor shall also have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	New Requirement	Full	This requirement is addressed in the Integrated Care Management Policy and in the Members in Foster Care, Guardianship and the Homeless Policy. In addition, MCO Report #85 2017 QI Plan & Evaluation evaluates performance measure (PM) rates for the individuals with special health care needs (ISHCN) cohort.	
19.2 Annual QAPI Review			Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results).	
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	Full - Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results) The requirement is demonstrated in the MCO Report #85 Annual Evaluation of Quality Improvement Program 2015.			

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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 to meet the needs of Members. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.	Key accomplishments in 2015 include: maintaining access and availability improvements and educating providers; process improvements in staffing, workflow and customer service representative training; informing members about transportation services and ways to access care; improving collaboration, coordination and continuity of care between BH providers and PCPs; integrating PH and BH; improving care related to antipsychotic use for children and adolescents, diabetes, and ADHD; reducing inpatient readmissions; designing and implementing a prevention and wellness program; managing QOC/adverse events; increasing the receipt of EPSDT services; improving CAHPS scores; improve rates for HEDIS and Healthy Kentuckians measures; begin preparing for the 2017 NCQA accreditation review. The MCO demonstrated improvements in CAHPS results in many categories as compared with 2014 results, and exceeded national averages for 20/28 adult categories and 16/24 categories for children. Barriers and opportunities for improvement were addressed with interventions (e.g. the member services department was relocated from off-site to the Louisville MCO office, allowing for collaboration with all departments to reach MCO improvement goals. Recognizing high volume episodes of diseases, the MCO has developed and maintained care management programs for Asthma, Coronary Artery Disease, Congestive Heart Failure,			

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	COPD, Chronic Renal Failure, Depression and Heart Diabetes Mellitus. The MCO reported a full review of these programs. Behavioral Health Readmission rates decreased in 2015.			
22.3 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.	Full - The requirement is addressed in the 2016 QAPI Program Description Appendix 1 entitled Organizational Goals and Objectives (Row 26); and page 23 pertaining to Compliance Committee major responsibilities. The requirement is addressed in the Policy and Procedure QI-002 External Quality Review (EQRO) and Aetna Better Health of Kentucky Policy and Policy and Procedure 8500.002 State Oversight (EQRO) Reviews), which describes the MCO's preparation and follow-up for state-mandated reviews, including those conducted by EQROs. The requirement is addressed in the Audit Contract Section Folder 22.3 subfolder EQRO- Quality Management Oversight Committee meeting minutes 9/26/16. The EQRO Report was discussed and all corrective action plan responses were documented as being sent in August 2016. The requirement is demonstrated in the 2016 QAPI Work Plan, which contains topics/activities for EQRO requests, EQRO focus studies, and EQRO Compliance review. The MCO has provided all documentation, medical records, and data as requested by IPRO.			

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The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of 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 - The requirement is addressed in the 2016 QAPI Program Description Appendix 1 entitled Organizational Goals and Objectives (Row 26); and page 23 pertaining to Compliance Committee major responsibilities. The requirement is addressed in Policy and Procedure QI-002 External Quality Review (EQRO) and Policy and Procedure 8500.002 State Oversight (EQRO) Reviews, which describes the MCO's preparation and follow-up for state-mandated reviews including those conducted by EQROs. The requirement is demonstrated in the 2016 QAPI Work Plan, which contains topics/activities for EQRO requests, EQRO focus studies, and EQRO Compliance review. The requirement is addressed in the Quality Management Oversight Committee meeting minutes of 9/26/16, which indicate the EQRO Report was discussed and all corrective action plan responses were documented as being sent in August 2016. The MCO has cooperated with and participated in all EQRO activities, providing documentation, data and medical records as requested. DMS allows MCOs to meet some federal and state requirements through deeming, where appropriate.			
22.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in	Full - The requirement is addressed in the 2016 QAPI Program			

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competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Description Appendix 1 entitled Organizational Goals and Objectives (Row 26); and page 23 pertaining to Compliance Committee major responsibilities. The requirement is addressed in Policy and Procedure QI-002 External Quality Review (EQRO) and Policy and Procedure 8500.002 State Oversight (EQRO), which describes the MCO's preparation and follow-up for state-mandated reviews including those conducted by EQROs. The requirement is demonstrated in the 2016 QAPI Work Plan, which contains topics/activities for EQRO requests, EQRO focus studies, and EQRO Compliance review. The requirement is addressed in Quality Management Oversight Committee meeting minutes 9/26/16, in which the EQRO Report was discussed and all corrective action plan responses were documented as being sent in August 2016. The MCO has cooperated with and participated in all EQRO activities, providing documentation, data and medical records as requested.			
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.	Full - This requirement is addressed in the 2016 QAPI Program Description Appendix 1 entitled Organizational Goals and Objectives (Row 26); and page 23 pertaining to Compliance Committee major responsibilities. The requirement is addressed in Policy and Procedure QI-002 External Quality Review (EQRO) and in the 2016 QAPI Work Plan,			

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Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.	which contains topics/activities for EQRO requests, EQRO focus studies, and EQRO Compliance review. Aetna has fully cooperated in 2016 and has provided all records and data for EQRO activities, as requested. In addition, Aetna provided documentation for the 2016 Detailed Technical Report production.			
22.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - The requirement is addressed in the 2016 QAPI Program Description Appendix 1 entitled Organizational Goals and Objectives (Row 26); and page 23 pertaining to Compliance Committee major responsibilities. The requirement is demonstrated in the 2016 QAPI Work Plan, which contains topics/activities for EQRO requests, EQRO focus studies, and EQRO Compliance review. The requirement is addressed in Quality Management Oversight Committee meeting minutes 9/26/16, in which the EQRO Report was discussed and all corrective action plan responses were documented as being sent in August 2016. The MCO made progress in addressing the areas not fully compliant, although some areas, specifically member involvement in QMAC and incorporation of member feedback into QI activities are the focus of ongoing MCO improvement efforts.			

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A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - The assignment of staff to perform follow-up concerning review findings is addressed in the External Quality Review Organization Policy QI-002 on page 2, second bullet. Responsible staff assigned to EQRO compliance is noted in the 2016 QAPI Work Plan in general categories: Compliance and QM. Demonstrated in QAPI Program description Page 27 under QM department responsibilities.			
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;	Full - The requirement is addressed in Quality Management Oversight Committee meeting minutes 9/26/16, in which the EQRO Report was discussed and all corrective action plan responses were documented as being sent in August 2016. The requirement is also addressed in the 2016 QAPI Program Description, page 13, pertaining to QMOC major responsibilities (assist in developing action plans; review and approve submitted action plans/progress reports).			
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; An extension to submit may be extended in accordance with Section	Full - The requirement is addressed in policy and procedure QI-002 External Quality Review Policy and in Quality Management Oversight Committee meeting minutes of 9/26/16, in which the EQRO Report was discussed and all corrective action plan responses were documented as being sent in August 2016. The MCO has made progress in addressing prior deficiencies.			

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40.4.D;				
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full - This requirement is addressed in the QAPI 2016 Program Description: Program Purpose on page 6, which states "Implementing action plans and activities to correct deficiencies and/or improve overall quality in the process of care and clinical operations" and "Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews." The requirement is addressed in the QAPI 2106 Program Description Goals and Objectives and Appendix 1. The requirement is demonstrated in the 2016 QAPI Work Plan, which contains topics for EQRO requests, EQRO focus studies, and EQRO Compliance review. As described previously, the MCO has made progress in addressing prior deficiencies.			
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	Full - The MCO submitted responses to the 2015 review findings, and the responses were considered in making the final review determinations. The MCO worked to develop and implement corrective actions.			
19.3 QAPI Plan			Includes review of MCO report #17 QAPI Work Plan, MCO Report #84 QAPI Program Description, MCO	

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			Report #21 MCO Committee Activity, and MCO Report #85 QI Plan and Evaluation (see Quarterly Desk Audit results).	
The Contractor shall have a written QAPI work plan that	Full - This requirement is evidenced in Report #84 2016 QAPI Program Description, Report #85 Annual Evaluation of Quality Improvement Program 2015, 2016 QAPI Work Plan, 2016 Healthy Kentuckian Work Plan, 2016 Prevention and Wellness Work Plan. The requirement is addressed in State Report #17, which addresses the QMOC's Quarterly review of accomplished versus planned activities on QI Work Plan.			
outlines the scope of activities and	Full - The requirement is addressed and demonstrated in the 2016 QAPI Work Plan/Q4 update, which includes the activities with rational for selection, NCQA accreditation requirement, topic, objective, responsible staff, goal/benchmark, start and due dates, status, date of completion, and comments on project status.			
the goals,	Full - The requirement is addressed and demonstrated in the 2016 QAPI Work Plan/Q4 update that contains a column for goal/objective and benchmark (where applicable).			
objectives, and	Full - The requirement is addressed and demonstrated in the 2016 QAPI Work Plan/Q4 update that contains a column for objective (where applicable).			
timelines for the QAPI program.	Full - The requirement is addressed and demonstrated in the 2016 QAPI Work Plan/Q4 update, that contains columns for start			

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	date, date due, and completion date.			
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.	Full - The requirement is addressed in the 2015 Annual Evaluation on page 120 : additional training in Milliman Care Guidelines to improve IRR scores in initial testing period, transition to Milliman Care Guidelines in Q42015, monitor the Neonatal Abstinence Program (NAS) to determine clinical efficacy and identify opportunities for improvement of the program, continued attempts to contact members prior to hospital discharge, provide education regarding discharge plans and follow-up appointments, and asses for identification of additional needs, enhance care coordination after discharge with follow-up phone calls to members, face to face visits between case management and members where appropriate, continued collaboration between concurrent review nurses and case management, ongoing training of prior authorization staff and identification of potential efficiencies in current practices, successful migration from Coventry Cares KY process/policies to Aetna, continued integration of bio-psychosocial model of care management and evaluate prior authorization list for opportunities to enhance MCO utilization and monitoring capabilities. The requirement is demonstrated in the 2016 QM Work Plan that contains activities related to accreditation, HEDIS, HK performance measures, CAHPS, EQRO, PIPs, access/availability, QM department functions, grievances/appeals, among other topics. The requirement is demonstrated in the HEDIS/Healthy			

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	Kentuckian/EPSDT/ Foster care Work Plan 2016. The requirement is demonstrated in the 2016 Prevention and Wellness Program, specifically goals to improve Medicaid CAHPS survey results. The requirement is demonstrated in committee meeting minutes, for example the February 18, 2016 QM/UM subcommittee (page 2-7 regarding continuity and coordination between medical and behavioral health, page 7-10 regarding continuity between ED and PCP).			
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full - The requirement is addressed in the 2016 QAPI Program Description- Quality Management Program Overview Page 6: one of the purposes of the quality management program is to comply with federal and state requirements; QAPI goals and objectives: one objective is to maintain compliance with local, state and federal regulatory requirements and accreditation standards. The QAPI Program Description on pages 8-10 states that the QAPI program is accountable to the Quality Management Oversight Committee (QMOC) and Board of Directors. The requirement is addressed in the QMOC charter and QM/UM Committee charter and in QMOC and QM/UM Committee meeting minutes.			
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - The requirement is addressed in the 2016 QAPI Program Description- pages 8-10, which state that the QAPI program is accountable to the Quality Management Oversight Committee (QMOC) and Board of Directors. Pages 11-12 discuss how			

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	direction and oversight is provided by Quality Management Oversight Bodies, and page 8 describes direction and oversight of QAPI program by Chief Medical Officer. The requirement is addressed in the QMOC charter and QM/UM Committee charter, as well as QMOC and QM/UM Committee meeting minutes.			
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full - The requirement is demonstrated in the QMOC meeting minutes, which describe review of the QM Program Description, QM Work Plan, Annual Evaluation, monthly QM updates and subcommittee reports. Evidence is also seen in QM/UM Committee meeting minutes, including review of routine reports (Utilization Trends, Semi-annual Credentialing Report, HEDIS reports, UM IRR report summary, Annual Evaluation).			
review on an annual basis of the QAPI program; and	Full - The requirement is addressed in the 2016 QAPI Program Description- pages 8-10, which state that the QAPI program is accountable to the Quality Management Oversight Committee (QMOC) and board of directors. Pages 11-12 discuss how direction and oversight is provided by Quality Management Oversight Bodies, page 8 describes direction and oversight of QAPI program by Chief Medical Officer, and page 10 discusses the Annual Quality management Evaluation. The requirement is addressed in the QMOC charter and QM/UM Committee charters, and demonstrated in the QMOC meeting minutes, which describe review of the QM Program Description, QM Work Plan and Annual Evaluation.			

Final Findings

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**
	Evidence is also seen in QM/UM Committee meeting minutes, including review of Annual Evaluation Report.			
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full - The requirement is addressed in the Annual Evaluation of the 2015 Quality Improvement Program in the Conclusions, Synopsis and Recommendations section (Page 92). The requirement is evidenced in the 2016 QAPI Work Plan (e.g. Continuity and Coordination of Medical Care and Behavioral Healthcare activity), as well as the HEDIS/ HK/ EPSDT/ Foster Work Plan 2016, and the Prevention and Wellness Program 2016. One of the areas noted in the Annual Review of the 2015 Quality Improvement Program was to increase member participation in the QMAC committee, which the MCO has continued to work on.			
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Full - This requirement is addressed in the 2016 QAPI Program Description- pages 8-10, which state that the QAPI program is accountable to the Quality Management Oversight Committee (QMOC) and Board of Directors; pages 11-12 discuss how direction and oversight is provided by Quality Management Oversight Bodies. The requirement is addressed in the QMOC charter and QM/UM Committee charter, and evidenced in QMOC and QM/UM Committee meeting minutes.			
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical	Full - This requirement is addressed in the QMOC Charter, which lists the membership as the CEO, COO, CFO, CMO, Compliance Officer, Director of Quality Management, Director of Medical Management, Director of Operations, Health Services Director			

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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**
disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	(UM), Health Services Director (CM), BH Director, Pharmacy Director, Network Director, and Community Development Manager. The requirement is demonstrated in the committee meeting minutes/attendance. The QM/UM committee has participation from members with expertise in specialized health care needs and this committee reports to the QMOC. The minutes from QM/UM meeting document continual recruitment efforts of BH providers to achieve an accurate cross-representation of in-network providers.			
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Full - This requirement is addressed in the QMOC Charter that states the committee will meet a minimum of 6 times a year, and more often, if necessary, and in the QM/UM Committee Charter that states the committee will meet monthly. The requirement is further demonstrated in meeting minutes that the MCO submitted. There were 5 QMOC meetings as of September 2016. There were 10 QM/UM meetings as of October 2016.			
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	Full - The requirement is addressed in the QMOC Charter: "The Quality Management Oversight Committee's primary purpose is to integrate quality management and performance improvement activities throughout the MCO and the provider network…and make sure the QAPI is integrated throughout the organization, and among departments, delegated organizations, and network providers."			

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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**
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.	Communication to providers and delegates is evidenced in the respective contracts – Network Capitation Agreement, section 2.7 Quality Improvement Utilization Management; Ancillary Provider Agreement, item #16 QAPI Program & Attachment B-2 QI Activities. The requirement is also communicated in the Provider Manual. The requirement is evidenced in the QMOC minutes and QM/UM Committee minutes, discussion of and reports from the delegation oversight committee and in QM updates to the committee. Minutes from the QM/UM meeting (October 20, 2016 address Avesis (subcontractor) Oversight and Audit Summary). Minutes from the February 29, 2016 QMOC meeting has a section for Committee updates.			
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.	Full - The requirement is addressed in the 2016 QAPI Program Description The requirement is demonstrated in the QM/UM Committee minutes and QMOC minutes by participation from across the organization.			
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including, but not limited to, monitoring and evaluation of Member's care and services, including the care and services of Members with special health	Full - The requirement is addressed in the 2016 QAPI Program Description. Staff resources include: clinical and professional staff, support from corporate and MCO staff including Medical Directors, UM staff, Network Management staff, Provider Relations staff, Compliance staff, IT support and Member Services staff. Analytic resources include data analysts, certified coders, Information Systems experts and actuarial experts.			

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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**
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.				
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	Full - The requirement is evidenced by the QAPI Work Plan/ Healthy Kentuckian Work Plan/ Prevention and Wellness Work Plan and associated Q4 updates submitted.			
19.4 QAPI Monitoring and Evaluation				
The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality	Full - The requirement is addressed in the 2016 QAPI Program Description under Quality Management Oversight Bodies (page 11), Objectives (page 7), Prevention and Wellness (page 48); QM/UM Committee (page 15). The requirement is addressed in Policy and Procedure QM 65 Clinical Practice and Preventive Services Guidelines Policy, QI-024 Clinical Practice Guidelines and Standards of Care Policy. The requirement is addressed in the QM/UM Committee Charter. The requirement is evidenced in the 2016 QAPI Work Plan,			

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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**
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.	UM/QM Committee meeting minutes and MCO Reports (e.g. #18 Monitoring Indicators Benchmarks and Outcomes). The requirement is demonstrated in the 2015 Annual Evaluation of Clinical Care, Section F. Clinical Guidelines and Section G. Quality Indicators – HEDIS/HK Section H.			
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - The requirement is addressed in the 2016 QAPI Program Description under Quality Management Oversight Bodies (page 11), Objectives (page 7), Prevention and Wellness (page 48); QM/UM Committee (page 15). The requirement is evidenced in the 2016 QAPI Work Plan (under Guidelines Activity row 24), UM/QM Committee meeting minutes and MCO Reports (e.g. #18 Monitoring Indicators Benchmarks and Outcomes). The requirement is demonstrated in the 2015 Annual Evaluation of Clinical Care, Section F. Clinical Guidelines and Section G. Quality Indicators – HEDIS/HK Section H.			
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - The requirement is evidenced in the 2016 QAPI Work Plan, the 2015 Annual Evaluation, and the QMOC meeting minutes. The requirement is demonstrated in the HEDIS/HK/ EPSDT/Foster			

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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**
	Work Plan 2016, Prevention and Wellness Program 2016, 2016 KY HEDIS Strategy document, 2016 CAHPS Analysis, 2016 CAHPS Member Survey State report #94, and HEDIS Report #96 (Interventions Summary, Barriers and Opportunities).			
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full - The requirement is evidenced in the 2016 QAPI Work Plan, the 2015 Annual Evaluation, and the QMOC meeting minutes. The requirement is demonstrated in the HEDIS/HK/ EPSDT/Foster Work Plan 2016, Prevention and Wellness Program 2016, 2016 KY HEDIS Strategy document, 2016 CAHPS Analysis, 2016 CAHPS Member Survey State report #94, and HEDIS Report #96 (Interventions Summary, Barriers and Opportunities).			
The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full - The requirement is addressed in the 2016 QAPI Program Description, Quality Management Oversight Bodies (page 11), Corporate Structure (pages 11-12), Health Plan Structure (pages 13-14), Committee Structure (pages 13-25), and QAPI Program Resources (pages 25-31). The requirement is addressed in the QMOC and QM/UM Committee Charters and demonstrated in the committee meeting minutes.			
The Contractor shall collaborate with existing provider quality improvement activities and to the extent possible, align with those activities to reduce duplication and to maximize outcomes.	Full - This requirement is addressed in the HEDIS/Healthy Kentuckian/EPSDT/ Foster Care Work Plan 2016. For example, collaboration is demonstrated specifically in efforts to increase the Frequency of Perinatal Care measures, where the use of a standardized Postnatal Depression tool is being utilized by BHPs and Community Health Centers, thereby aligning Perinatal and Behavioral Health QI activities. The requirement is also			

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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**
	demonstrated in Annual Dental Visit Activities through collaboration with Dental Bus Screening events, attending the EPSDT Meeting with Department of Medicaid services and attending DCBS regional EPSDT Coordinator meetings. The requirement is demonstrated in the 2016 QAPI Program Description Appendix 1- Goals and Objectives: Row #2, Row #3, and Row #27. On site, staff indicated that collaboration included special society collaboration in practice guideline development, participation with local American Diabetes Association for member outreach by diabetes educators and other regional diabetes collaboration.			
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 - This requirement is addressed in the 2016 QAPI Program Description, Quality Improvement Activities/Performance Improvement Projects policy 8400.5 and the 2016 QM Work Plan, which includes the PIPs. This requirement is evidenced in submission of MCO Reports #90 PIP Proposal, MCO Reports #92 and quarterly MCO Reports #19 Performance Improvement Projects. In 2016, the MCO submitted the Increasing Follow-up Care After Hospitalization for Mental Illness Proposal. The following PIP Reports were also submitted: Follow-up Care for Children Prescribed ADHD Medication-Interim, Improving Postpartum Care-Baseline, Hospital Readmissions- Final, Diabetes: Increasing Diabetes Testing and Screenings- Interim, Measuring the Appropriate Use and Management of Antipsychotics for Children			

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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**
	and Adolescents-interim, and Prevention of Physical Health Risks in the SMI Population-Baseline. PIP topics include one BH and one PH annually, as required. Each of the PIP topics was approved by DMS. The 2015 Use of Antipsychotics PIP and 2016 Preventive Care for Members with Serious Mental Illness are statewide collaborative directed by DMS.			
The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members and Potential Enrollees upon request.	Full - This requirement is addressed in Policy and Procedure QI-020 Preventive Health Guideline Policy and QI-024 Clinical Practice Guidelines and Standards of Care Policy, QM65 Clinical Practice and Preventive Services Guidelines Policy/ Amendment, the 2016 QAPI Program Description (page 37), the 2016 QAPI Work Plan and the QM/UM Committee Charter. The QM/UM Committee Meeting minutes for September 2016 describe the Clinical Practice Guidelines process and updates. This requirement is evidenced by Summary of Disease Management Program Descriptions Document and The National Medicaid Quality Management Clinical Practice Guidelines and Preventive Health Guidelines Process. There is evidence of communication to providers via the Provider Manual which describes clinical guidelines and where to locate them on the MCO's website, via fax blast, and via mailings and newsletters. The MCO participates with the Healthy Babies initiative.			

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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**
	There is evidence of communication to members in the Member Handbook, which includes EPSDT guidelines and recommendations for routine testing/screening and cancer screenings, newsletters, mailings and at community events.			
Mental Health and Substance Use practice guidelines shall also be submitted to the Department and DBHDID.	Full - A notification e-mail was provided which was sent to DMS: "In accordance with our contract, Section 19.4, please consider this notification of our BH clinical practice guidelines for 2016. Our BH guidelines were approved in our September, 2016 QMUM committee meeting." Additionally, the website was updated to reflect these guidelines. The requirement is evidenced in the September 2016 QM/UM meeting minutes, including the adoption of additional clinical practice guidelines: Depression, Opioid Use Disorders, Adult Attention Deficit Hyperactive Disorder and Use of Antipsychotics in Children and Adolescents. This document was also provided for review. The Guideline Adoption Summary Document chronicles the timeline for guideline adoption including Alcohol, Depression and Treatment of Attention Deficit/Hyperactivity Disorder in Children and Adolescents.			
The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals;	Full - This requirement is addressed in Policies and Procedures QI-020 Preventive Health Guideline Policy and QI-024 Clinical Practice Guidelines and Standards of Care Policy, QM65 Clinical Practice and Preventive Services Guidelines Policy/ Amendment, the 2016 QAPI Program Description (page 37), the 2016 QAPI Work Plan and the QM/UM Committee Charter.			

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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**
	QM/UM Committee Meeting minutes for September 2016 describe Clinical Practice Guidelines process and updates. The requirement is evidenced by the Summary of Disease Management Program Descriptions Document and The National Medicaid Quality Management Clinical Practice Guidelines and Preventive Health Guidelines Process. MCO clinical practice guidelines are derived from the American Heart Association, American Medical Association, National Heart Lung and Blood Institute, American Psychiatric Association, and American Academy of Pediatrics, as noted in the 2016 CPG_PHG for QMUM document. Adoption of guidelines is evidenced in the 2016 QAPI Work Plan and QM/UM Committee meeting minutes.			
consider the needs of Members;	Full - The MCO gathers data and conducts analyses to assess the characteristics and needs of the membership. This requirement is addressed in the 2016 QAPI Program Description. This requirement is also evidenced in the 2015 Annual Evaluation (pages 4-16).			
developed or adopted in consultation with contracting health professionals, and	Full - This requirement is addressed in Policy and Procedure QI-024 Clinical Practice Guidelines Policy and QM/ UM Committee Charter.			

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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 requirement is demonstrated in QM/UM Committee meeting minutes.			
reviewed and updated periodically.	Full - This requirement is addressed in Policy and Procedure QI-024 Clinical Practice Guidelines Policy and the QM/UM Committee Charter. This requirement is demonstrated in QM/UM Committee meeting minutes (e.g. QM/UM September 2016 meeting).			
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 - This requirement is addressed in the 2016 QAPI Program Description Health Management Section under Clinical Practice Guidelines and Preventive services Guidelines (page 37-38) and Policy and Procedure QI-031 Self-Management Tools. This requirement is demonstrated in the QM/UM committee meeting minutes discussing Clinical practice Guidelines- September 22, 2016. IRR Results were reported at December 15, 2016 QM/UM Meeting.			
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at health improvement for selected performance measures, in either the actual outcomes or processes used to affect those outcomes. Once	Full - This requirement is addressed in the 2016 QAPI Program Description, QAPI Goals and Objectives (pages 7 and Appendix-1) and Performance Improvement Projects (Focused Studies) (page 32). The requirement is also addressed in the 2016 QAPI Work Plan and the 2016 HEDIS/ EPSDT/HK/Foster Work Plan.			

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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 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.	The requirement is evidenced in MCO Report # 96 Audited HEDIS Data and submission of HK data, MCO Report #19 Performance Improvement Projects and MCO Report #94 CAHPS Analysis. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.			
Additionally, the Department, Contractor, and the EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	Full - The MCO follows the HEDIS measure rotation schedule. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO.			
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to Individual Members with Special Health Care Needs (ISHCN).	Full - Aetna reports the ISHCN performance measures annually via submission of rates and data to the EQRO, IPRO for performance measure validation.			

Final Findings

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 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.	Full - The requirement is addressed by trending of measures and strategies to improve demonstrated in the 2015 Annual Evaluation of the Kentucky Quality Improvement Program.			
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.	Full - To date, DMS has not chosen to set performance improvement thresholds for the performance measures. The Performance Measure set is evaluated annually by DMS and the EQRO, IPRO. The MCO reports the full set of performance measures annually via MCO Report #96 Audited HEDIS Reports and submission of rates and data to the EQRO, IPRO for performance measure validation.			
20.3 Reporting HEDIS Performance Measures			Includes review of MCO Report #96 Audited Healthcare Effectiveness Data and Information Set (HEDIS) Reports (see Quarterly Desk Audit results).	
The Contractor shall be required to collect and report HEDIS data annually.	Full - This requirement is addressed in the 2016 QAPI Work Plan, which includes tasks for DMS reporting and 2016 Healthy			

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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**
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 each August 31st.	Kentuckian Work Plan. The MCO submitted MCO Report #96 Audited HEDIS Reports to DMS as required.			
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.	Full - This requirement is addressed in the 2016 QAPI Work Plan and Health Kentuckian Work Plan. The requirement is demonstrated in MCO Report #96 Audited HEDIS Results, which contains the HEDIS IDSS and bar graphs, trends, and benchmarking for the HEDIS measures, stratified data, as well as Healthy Kentuckian measures.			
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.	Full - This requirement is addressed in the QAPI 2016 Work Plan and 2016 Healthy Kentuckian Work Plan. The requirement is demonstrated in MCO Report #96 Audited HEDIS Results which contains bar graphs, trends, and benchmarking for the HEDIS measures, stratified data, as well as Healthy Kentuckian measures.			

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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**
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.	Not Applicable - DMS has not chosen a subset of measures for evaluation. Annually, in collaboration with the EQRO, DMS evaluates the measures required for reporting.			
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	Not Applicable - DMS has not chosen a subset of measures for evaluation. Annually, in collaboration with the EQRO, DMS evaluates the measures required for reporting.	Not Applicable	On site, the MCO indicated there were no measures identified by DMS.	
The Department further reserves the right to implement and require different quality measures. The Contractor shall be given no less than ninety (90) days to comply with any new quality	New Requirement	Not Applicable	On site, the MCO indicated there were no measures identified by DMS.	

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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**
measurement requirement.				
20.4 Accreditation of Contractor by National Accrediting Body				
If the Contractor holds a current NCQA accreditation status it 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 Review Tool (IRT) Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department	Full - The MCO holds NCQA Accreditation for the period 8/2014 – 8/2017 and has provided the documentation to DMS. The next accreditation survey will occur in 2017.			
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the Contractor shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO contract with the Commonwealth.	Full - The MCO holds NCQA Accreditation for the period 8/2014 – 8/2017 and has provided the documentation to DMS. The next accreditation survey will occur in 2017.			

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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**
20.5 Performance Improvement Projects (PIPs)			Includes review of MCO Reports #19 Performance Improvement Projects (PIPs), #90 PIP Proposal, and #92 PIP Measurement (see Quarterly Desk Audit results).	
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 characteristics and health risks; and the interest of Members in the aspect of care/services to be addressed.	Full - This requirement is addressed in Policy 8400.05 Quality Improvement Activities/Performance Improvement Projects. The requirement is evidenced in annual MCO Report #90 PIP Proposals, annual MCO Reports #92 PIP Measurements, and quarterly MCO Report #19 PIP updates. MCO PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions, (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes, and (2016) Preventive Care for Members with Serious Mental Illness and Postpartum Depression and PIP Proposal for Increasing Follow-Up Care After Hospitalization for Mental Illness (2016). The MCO provided strong rationales for its MCO-chosen PIP topics, including literature citations, national statistics and data, and MCO-specific data. The BH topics for 2015 and 2016 are statewide collaborative DMS-directed topics.			
The Contractor shall continuously monitor its own performance on a	Full - The requirement is addressed in Policy and Procedure 8400.05 Quality Improvement Activities/Performance			

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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**
variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality,	Improvement Projects. The requirement is evidenced in annual MCO Report #90 PIP Proposals, annual MCO Reports #92 PIP Measurements, and quarterly MCO Report #19 PIP updates. MCO PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions, (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes, and (2016) Preventive Care for Members with Serious Mental Illness and Postpartum Depression and PIP Proposal for Increasing Follow-Up Care After Hospitalization for Mental Illness (2016). The MCO provided strong rationales for its MCO-chosen PIP topics, including literature citations, national statistics and data, and MCO-specific data. The BH topics for 2015 and 2016 are statewide collaborative DMS-directed topics.			

Final Findings

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**
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.				
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full - The requirement is addressed in Policy and Procedure 8400.05 Quality Improvement Activities/Performance Improvement Projects. The requirement is evidenced by the MCO's PIP Reports submissions. The MCO collaborates with local health departments, MHNet, Avesis, DCBS, participating facilities and providers, community agencies/ events and other Medicaid MCOs for collaborative PIP topics. In the past year, the MCO has maintained increased engagement with the community as evidenced by PIP and HEDIS interventions.			
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 and	Full - This requirement is demonstrated in Coventry's participation in EQRO activities and statewide collaborative PIPs. The requirement is demonstrated on Page 32 of the 2016 QAPI Program description: "PIP topics are identified either from areas of importance or weakness…examination of relevant clinical,			

Final Findings

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**
establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection.	survey, financial, demographic, and/or encounter data that relate to quality of care." The MCO has collaborated with local diabetes improvement initiatives as described above.			
The Contractor shall monitor and evaluate the quality of care and services by initiating at least one PIP each year and participating in one collaborative PIP each year. The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED Services. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department shall require Contractor to (i) implement an additional PIP specific to the Contractor,	Full - This requirement is addressed in Policy and Procedure 8400.05 Quality Improvement Activities/Performance Improvement Projects. The requirement is evidenced in annual MCO Report #90 PIP Proposals, annual MCO Reports #92 PIP Measurements, and quarterly MCO Report #19 PIP updates. MCO PIP topics include: (2013) Major Depression and ED Utilization, (2014) ADHD and Inpatient Readmissions, (2015) Use of Antipsychotics in Children and Adolescents and Care for Diabetes, and (2016) Preventive Care for Members with Serious Mental Illness and Postpartum Depression and PIP Proposal for Increasing Follow-Up Care After Hospitalization for Mental Illness (2016). The MCO provided strong rationales for its MCO-chosen PIP topics, including literature citations, national statistics and data, and MCO-specific data. The MCO submitted revised PIP proposals, as required. The PIP topics include one behavioral health and one physical health topic for each year. DMS has not directed MCO to conduct an additional PIP.			

Final Findings

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**
if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS;. The Contractor shall submit reports on PIPs as specified by the Department.	The BH topics for 2015 and 2016 are statewide collaborative DMS-directed topics.			
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 requirement is evidenced in annual MCO Reports #90 PIP Proposals and MCO Report #92 PIP Measurements and quarterly in MCO Reports #19 PIPs in progress. The MCO used the required templates for its proposals, baseline reports and interim reports.			
A. Topic and its importance to enrolled members;	Full - The topic relevance for MCO PIPs was well supported. The MCO addressed prior and current EQRO and DMS recommendations.			
B. Methodology for topic selection;	Full - The rationale for each of the PIPs included national, statewide and MCO-specific data as well as literature citations to justify topic selection. The MCO addressed prior and current EQRO and DMS recommendations.			
C. Goals;	Full - Goals/targets for improvement are included in each of the PIP proposals for each indicator. Goals are based on the NCQA guidelines for meaningful improvement. The MCO addressed prior and current EQRO and DMS recommendations.			
D. Data sources/collection;	Full - Data sources and collection procedures were described in			

Final Findings

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**
	each of the four PIP proposals. Many of the measures follow HEDIS specifications for data sources and methodology.			
E. Intervention(s) – not required for projects to establish baseline; and	Full - Interventions were described in the PIP proposals and reports. The MCO implemented interventions that were designed to address barriers to care.			
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.	Full - Results were clearly presented and improvement was documented in final report. **Recommendation for Aetna** Presenting trended year over year data in one table would enhance the Readmission PIP report, as noted in the PIP review.			
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Full - Aetna met this requirement in final reports.			
B. Did Members participate in the performance improvement project;	Full - Aetna met this requirement in final reports.			
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	Full - Aetna met this requirement in final reports.			
D. How financial impact might	New Requirement	Full	On site, the MCO discussed how they	

Final Findings

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**
determine sustainability of improvement achieved;			might conduct and interpret an analysis of how financial impact (e.g., financial drivers such as care management staffing resources, data entry resources, information systems resources, member financial incentives, and provider financial incentives) might determine sustainability of improvement achieved beyond the PIP timeframe. The MCO provided specific examples of how they are currently redirecting savings into sustaining PIPs for prenatal smoking and diabetes.	
E. Were the results and conclusions made available to members, providers and any other interested bodies;	Full - Aetna included an abstract in final reports.			
F. Is there an executive summary;	Full - Aetna included an abstract in final reports.			
G. How could findings be reported to a broad audience of relevant stakeholders or the general public; and	New Requirement	Full	The Final PIP for Safe & Judicious Use of Antipsychotics in Children was shared with corporate staff and providers at Quality Management/Utilization Management (QMUM); however, neither members nor a broad audience of relevant stakeholders or the general public were informed. On	

Final Findings

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**
			site, the MCO explained that the annual summary includes PIP findings and is shared with the QMAC, at the annual interview with DMS, and at QMUM, which includes physicians external to the MCO.	
H. Do illustrations – graphs, figures, tables – convey information clearly?	Full - Results were clearly presented in tables. Rates for each measurement period were presented in separate tables in interim and final report.			
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement	Full - Aetna utilized standard, appropriate indicators and identified performance goals.			
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that	Full - Aetna demonstrated sustained improvement in readmission rates in the final Readmission PIP report.			

Final Findings

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**
resulted in improvement. The timeframes for reporting:				
A. Project Proposal including baseline measurement – due September 1 of Contract year. Proposal with baseline measurement is required upon submission of completed PIP. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full - MCO Reports #90 were submitted timely.			
B. 1st Remeasurement – no more than one calendar year after baseline measurement and no later than September 1 of the Contract year following baseline measurement.	Full - MCO Reports #92 were submitted timely.			
C. Conclusion – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year when the PIP concludes.	Full - MCO Reports #92 were submitted timely.			
20.6 Quality and Member Access Committee			Includes review of MCO Report #21 MCO Committee Activity and MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	

Final Findings

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 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 MCO held three QMAC meetings in 2016 (3/23/16, 6/15/16, 9/23/16). Three members attended the first meeting, but MCO members were not in attendance at subsequent meetings. Member advocates and community representatives were well represented at all meetings. The MCO onsite staff described ongoing efforts to solicit member engagement, and a weekly interdepartmental meeting has been established to share input obtained from all staff with direct member interaction. **Recommendation for Aetna** Aetna should continue efforts to engage members in the QMAC.			
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. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Responsibilities of	Full - This requirement is addressed in the QMA C Charter. The application for membership on QMAC includes optional queries regarding demographic characteristics. Three members attended the first of three 2016 meetings, but MCO members were not in attendance at subsequent meetings. Member advocates and community representatives reflect various age groups and geographies. The MCO onsite staff described ongoing efforts to solicit member engagement in QMAC.			

Final Findings

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 Committee shall include:	**Recommendation for Aetna** Aetna should continue efforts to engage members in the QMAC, and ensure that there is membership representative of MCO enrollee characteristics.			
A. Providing review and comment on quality and access standards;	Substantial - Meeting minutes include evidence of review of quality standards. Access standards did not appear to have been addressed by the QMAC in 2016; however, the committee did discuss network adequacy for adult care and specialists. **Recommendation for Aetna** The MCO should ensure discussion of access standards in the QMAC. **Final Review Determination** No Change. Meeting minutes do not seem to be a review of access standards, just a statement about specialists.	Full	This requirement is addressed in the 2018 Q1 QMAC meeting minutes, which includes a discussion of behavioral health member survey satisfaction findings regarding access and quality of care. The HEDIS summary (MCO Report #96) is submitted and reviewed by QMAC, and is broadcast via webinar so that other regions scheduled at other times can stay informed at all times.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Full - QMAC committee minutes include evidence of review of Grievances and Appeals.			
C. Providing review and comment on Member Handbooks;	Full - QMAC Committee minutes include discussion of the Member Handbook.			
D. Reviewing Member education materials prepared by the Contractor;	Full - QMAC committee minutes include discussion of the Member Handbook, the member website, MCO Report Card and			

Final Findings

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**
	provider directory.			
E. Recommending community outreach activities; and	Full - QMAC committee minutes reflect discussion of member and community involvement activities.			
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - QMAC committee minutes include discussion of grievances and appeals, the QAPI Program Description, the QM Work Plan, and oral health barriers to inform oral health care planning. <u>Final Review Determination</u> Changed to Full. <u>Recommendation for Aetna</u> The QMAC is a valuable resource for identifying impact of policies on members. Aetna should continue to encourage member input and provide opportunity for active discussion in QMAC meetings.			
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - A member roster was submitted to the Department in quarterly report #22, which also addresses attendance of members.			
21.5 Assessment of Member and Provider Satisfaction and Access			Includes review of MCO Report #94 Member Surveys, Report #95 Provider Surveys (see Quarterly Desk Audit results)	
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services	Full - Aetna conducted CAHPS member surveys for adults and children, and these were submitted in MCO Report #94.			

Final Findings

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**
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.	Aetna conducted a Provider Satisfaction survey, submitted to the Department in MCO Report #95.			
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - Aetna conducted CAHPS member surveys for adults and children, and these were submitted in MCO Report #94.			
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.	Full - This requirement is addressed in the 2015 Annual QAPI Evaluation. As evidence in MCO Report #22, Aetna conducted a Care Management survey in 2016 that addressed members enrolled in case of disease management.			
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Full - This requirement is addressed in the 2016 QM Work Plan and MCO Report #95.			
The Department shall review and approve any Member and Provider				

Final Findings

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**
survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used 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 - This requirement is addressed in the 2016 QM Work Plan and MCO Reports #94 and #95.			
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - Aetna submitted results to the Department in MCO Reports #94 and 95. CAHPS results were presented to the QMAC committee as per minutes.			
38.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Full - Includes review of MCO Report #16 Summary of QI Activities and MCO Report #17 QAPI Work Plan (see Quarterly Desk Audit results) This requirement is addressed in the 2016 QM Program Description and 2016 QM Work Plan, and is evidenced in MCO Reports #16 and #17.		Includes review of MCO Report #16 Summary of QI Activities and MCO Report #17 QAPI Work Plan (see Quarterly Desk Audit results).	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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	4	0	0	0
Total Points	12	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

QI Program Description (MCO Report #84)
QI Work Plan (MCO Report #17)
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports (MCO Reports #19, 90 and 92)
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

Reports

Annual QI Evaluation Report (MCO Report #85)
HEDIS Final Audit Report and IDSS rates (MCO Report #96)
Healthy Kentuckians Outcomes Measures Report
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
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
MCO Committee Activity (MCO Report #21)

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
25.0 Member Grievances and Appeals				
25.1 General Requirements The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B and 42 CFR 438 Subpart F. The Department shall provide a standardized form for Contractors to utilize for a Member to begin the Contractor's grievance and appeal process.				
25.2 Member Grievance and Appeal Policies and Procedures				
The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in compliance with the notice, timeliness, rights and procedures in 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. Grievance and Appeal policies and procedures shall include, but not be limited to:	Deem for 2017			
A. Provide the Member the opportunity to present evidence and allegations of fact or law, in person as well as in writing; The Contractor must inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals as specified in 42 CFR 438.408(b) and (c);	New Requirement	Minimal	Page 12 of the Member Appeals Policy 3100.70 states, "Aetna… will inform the member of the limited time for presenting evidence… in person as well as in writing in the case of expedited …"; however, this policy does not state that the member will be informed "sufficiently in advance of the	Agree- Acknowledgement letter has been revised to reflect relevant timeframes. Note: Updated letter will be pending DMS approval

Final Findings

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**
			resolution time frame for appeals and expedited appeals." The file review letters do include the attachment, "Grievances and Appeal Rights," which communicates the overall timeframe by stating, "You must file your appeal no later than 30 calendar days from the date on the last decision letter we sent you… we'll make a decision about your appeal within 30 days from the date we get it." The information communicated in the member handbook on page 54 states that if the member calls to tell the MCO about their appeal, the MCO will require a written appeal, and that the member will have 10 days from the date of the letter with the appeal form to include any information, but the grievance/appeal acknowledgement letter states that the member has only 7 days to submit additional information. **Recommendation for MCO** The MCO should review and revise the grievance/appeal acknowledgement letter to clearly and consistently communicate the relevant timeframes.	
B. Provide the Member and the Member's representative the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the direction of the Contractor, in connection with the appeal of the adverse benefit	New Requirement	Minimal	Page 12, second bullet of the Appeal Process Section of KY 3100.70 Member Appeals Policy states, "The member and his or her representative are provided with an opportunity, before and during the appeals process, to examine the member's case file,	Agree- Member NOA letters have been updated to include more comprehensive language to address all aspects of the requirement Note: Updated letters will be pending DMS

Final Findings

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. This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFRC.F.R. 438.408(b) and (c);			including medical records, and any other documents and records considered during the appeals process free of charge." However, the policy does not address these two specific new contractual requirements: 1) "any new or additional evidence considered, relied upon, or generated by the Contractor, or at the direction of the Contractor", and 2) "sufficiently in advance of the resolution timeframe for appeals as specified." Nor are these two specific requirements communicated to the member in any of the three appeal acknowledgement letters provided by the MCO or in the member handbook. The on-site file review also showed lack of communication of this requirement in the notice of adverse determination letters. **Recommendation for MCO** The MCO should add more comprehensive language to address all aspects of this requirement in the member letter regarding the notice of adverse determination.	Approval. KY 3100.70- Member Appeals policy also updated on page 13 with specific contract language.
C .Take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;	Deem for 2017			
D. Consider the Member, the Member's representative, or	Deem for 2017			

Final Findings

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 legal representative of the Member's estate as parties to the appeal;				
E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	Deem for 2017			
F. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a grievance or appeal;	Full - This requirement is addressed on page 12 in the 6th bullet of the section "Appeal Process" of "2016 Member Appeals – 3000.70.d.doc" (A-KY 3100.70 Member Appeals). Policy states that confidentiality is maintained for all members who file an appeal or grievance, and on page 8 in the "Investigation and Documentation" section of "2016 Member Grievances-3100.doc" (A-KY 3100.90 Member Complaint Grievance). Policy states that appeals and grievances are tracked in "Aetna Better Health's Dynamo Appeal and Grievance (DAG) application."			

Final Findings

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**
G. Ensure that a grievance or an appeal is disposed of and notice given as expeditiously as the Member's health condition requires but not to exceed 30 days from its initiation; If the Contractor extends the timeline for an appeal not at the request of the Member, the Contractor shall make reasonable efforts to give the Member prompt oral notice of the delay and shall give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file another grievance if he or she disagrees with that decision. Additionally, if the Contractor fails to resolve an appeal within this 30-day timeframe, the Member is deemed to have exhausted the Contractor's internal appeal process and may initiate a State Fair Hearing;	Substantial - Includes grievance file review results. This requirement is addressed on page 3 under "Timelines" and page 15 under "Written Appeal Decision Letter (Pre-Service, Expedited and Post-Service)" of "2016 Member Appeals – 3000.70.d.doc" (A-KY 3100.70 Member Appeals), on page 3 under "Timelines", page 7 under "Grievance Types", and page 8 under "Grievance Resolution and Notification" of "2016 Member Grievances-3100.doc" (A-KY 3100.90 Member Complaint Grievance). <u>Member Grievance - Random File Review Results</u> 9 of 10 were resolved timely. 1 of 10 did not have notification of resolutions sent within 30 days due to conversion to QNXT. <u>Member Grievance – Quality File Review Results</u> 9 of 10 were resolved timely. 1 of 10 did not have notification of resolutions sent within 30 days due to conversion to QNXT. <u>Member Appeal File Review Results</u> 10 of 10 were resolved timely.	Full	Includes member grievance – random, member grievance – quality, and member appeal file review results. The first part of this requirement is addressed in the KY 3100.70 Member Appeals Policy. The attachment to the member letter regarding the notice of adverse determination does address the second part of this requirement, "Additionally, if the Contractor fails to resolve an appeal within this 30-day timeframe, the Member is deemed to have exhausted the Contractor's internal appeal process and may initiate a State Fair Hearing". **<u>Member Grievance – Random File Review Results</u>** Ten (10) of 10 files met the timeliness standard. Nine (9) of 10 files met the requirement for acknowledgment of receipt within 5 working days of receipt of the grievance and included expected date of resolution; 1 of 10 files was not applicable due to resolution within 5 days. Three (3) of 10 files were granted an extension, with no (0) member requests for extension. Three (3) of 3 files with extension met the requirement for a decision within 14 days. Three (3) of 3 files	

Final Findings

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**
	Recommendation for Aetna The MCO should ensure that grievances are resolved timely, or if necessary, an extension is requested.		with extension met requirement for providing member with a written notice of reason for the extension within 2 working days of the decision to extend the timeframe if member did not request the extension. **Member Grievance – Quality File Review Results** Six (6) of 6 files met the timeliness standard.	
H. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Deem for 2017		Includes member grievance – random, member grievance – quality, and member appeal file review results.	
I. If the grievance involves a Medical Necessity determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;	Deem for 2017		Includes member grievance – random, member grievance – quality, and member appeal file review results.	
J. Process for informing Members, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Deem for 2017			

Final Findings

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**
K. Provide assistance to Members in filing a grievance if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;	Deem for 2017			
L. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Deem for 2017			
M. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Deem for 2017			
N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Full - Includes grievance file review results MCO provided documentation of the use of Microsoft Word's Readability analysis. Aetna requires 9.9 and below for providers and 5.5 and below for members. Also, 2 staff are required to review each document before mailing. <u>Member Random Grievance File Review Results</u> 10 Random Member Grievance Files were reviewed. 10 of 10 were fully compliant. <u>Member Quality Grievance File Review</u>		Includes member grievance – random and member grievance – quality file review results.	

Final Findings

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**
	Results 10 of 10 files were fully compliant.			
O. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	Full - This requirement is addressed on page 129 under "Member Complaints" section of "2017 Provider Manual.doc" (Aetna Better Healthy Provider Manual). This addresses both the provider and member's right to an appeal of grievance decision.			
P. Provide for continuation of services, if appropriate, while the appeal is pending;	Full - This requirement is addressed on third paragraph on page 129 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual), on page 76 under "Your benefits during the appeal or State Fair Hearings" in "2017 Member Handbook," on page 65 of under "Your benefits during the appeal or State Fair Hearings" in "2016 Member Handbook," and on page 6 under the 8th bullet of "Communication of Rights" of 2016 Member Appeals – 3000.70.d.doc" (A-KY 3100.70 Member Appeals).			
Q. Provide expedited appeals relating to matters which could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function;	New Requirement	Full	This requirement is addressed in the Member Appeals Policy 3100.70.	
R. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish	New Requirement	Full	This requirement is addressed in the Member Appeals Policy 3100.70.	

Final Findings

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 earliest possible filing date for the appeal and must be confirmed in writing;				
S. Not require a Member or a Member's representative to follow an oral request for an expedited appeal with a written request;	Full - This requirement is addressed on page 8 under 5th bullet of "Appeal Request" and under the 4th bullet of page 9 of "2016 Member Appeals – 3000.70.d.doc" (A-KY 3100.70 Member Appeals), on page 131 under "Expedited Appeals" section of "2017 Provider Manual.doc" (Aetna Better Health Manual), and on page 52 and 74 of "Member Services Member Handbook" under "Expedited (faster) appeals."			
T. Inform the Member of the limited time to present evidence and allegations of fact or law in the case of an expedited appeal;	Deem for 2017			
U. Acknowledge receipt of each grievance and appeal;	New Requirement	Full	This requirement is addressed in the Member Appeals Policy 3100.70 and the Grievance Policy 3100.90.	
V. Provide written notice of the appeal decision in a format and language that, at a minimum, meet the standards described in 42 90 CFR 438.10 and for notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice;	New Requirement	Full	This requirement is addressed in the Member Appeals Policy 3100.70.	
W. Provide for the right to request a hearing under KRS Chapter 13B;	Deem for 2017			

Final Findings

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**
X. Allows a Provider to file a grievance or appeal on the Member's behalf as provided in 907 KAR 17.010; and	Deem for 2017			
Y. Notifies the Member that if a Service Authorization Request is denied and the Member proceeds to receive the service and appeal the denial, if the appeal is in the Contractor's favor, that the Member may be liable for the cost.	Deem for 2017			
If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: A. The Member withdraws the appeal or request for a State Fair Hearing;, B. The Member does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision, C. A State Fair Hearing decision adverse to the Member is made,	Deem for 2017			
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, or CMS upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later. The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or	Deem for 2017			

Final Findings

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 resolved, the resolution, the notices of final decision to the Member, and all other pertinent information. Documentation regarding the grievance shall be made available to the Member, if requested.				
Grievance File Review				
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. KAR S 17:010 Section 4 (2) (a)	Substantial - Includes grievance file review results. This requirement is addressed in the first paragraph on page 6 of "2016 Provider Grievances – 6300.doc," in the second bullet under "Acknowledgement and Grievances" on page 8 of "2016 Member Grievances – 3100.doc," on page 73 under "Complaints" in "2017 Member Handbook," in the first bullet point on page 62 in "2016 Member Handbook" in the 2nd paragraph on page 3,,on page 5 of "Rights Backer-Sample.doc," and in the 4th paragraph of "Provider Complaints" on page 128 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual). <u>Member Random Grievance File Review Results</u> 10 Member Random Grievance Files were reviewed. 9 of 10 were resolved timely.	Full	Includes member grievance – random and member grievance – quality file review results. This requirement is addressed in the Grievance Policy 3100.90. **<u>Member Grievance – Random File Review Results</u>** Nine (9) of 10 files met the requirement for acknowledgment of receipt within 5 working days of receipt of the grievance; 1 of 10 files not applicable due to being resolved prior to days of receipt **<u>Member Grievance – Quality File Review Results</u>** Six (6) of 6 files met the requirement for acknowledgment of receipt within 5 working days of receipt of the grievance.	.

Final Findings

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**
	1 of 10 did not have acknowledgement letters sent within 5 days due to conversion to QNXT. Member Quality Grievance File Review Results 9 of 10 were resolved timely. 1 of 10 did not have acknowledgement letters sent within 5 days due to conversion to QNXT. **Recommendation for Aetna** MCO should assure that acknowledgement letters are sent timely.			
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	Substantial - Includes grievance file review results. This requirement is addressed in the first paragraph on page 6 of "2016 Provider Grievances – 6300.doc," in the second bullet under "Acknowledgement and Grievances" on page 8 of "2016 Member Grievances – 3100.doc," on page 73 in "2017 Member Handbook," in the first bullet point on page 62 of "2016 Member Handbook," in the 2nd paragraph on page 3 and on page 5 of "Rights Backer-Sample.doc," and in the 4th paragraph of "Provider Complaints"	Substantial	Includes member grievance – random and member grievance – quality file review results. This requirement is addressed in the Grievance Resolution Letter Template. **Member Grievance – Random File Review Results** Ten (10) of 10 files met both the timeliness standard and the requirement for documentation of the investigation of the substance of the grievance, including any aspect of clinical care involved.	Agree- Quality audits are performed on all grievance and appeals. See attached KY 3100.97 Appeal and Grievance Real Time Quality Assurance (QA) Policy A-KY 3100.97 Appeal and Grievan

Final Findings

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**
	on page 128 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual). Member Random Grievance File Review Results 9 of 10 files met the standard for timeliness. 1 did not meet the standard for timeliness due to conversion to QNXT. 10 of 10 files demonstrated a complete investigation. 10 of 10 resolution notices contained all information considered in the investigation. 10 of 10 files contained the findings and conclusions. 10 of 10 files contained the disposition of the grievance. 10 of 10 resolution notices were written in a manner to ensure understanding. **Recommendation for Aetna** If MCO will use standard language, such should be pre-approved by the Department or the MCO should include all information considered in the investigation.		Nine (9) of 10 files met each of the following requirements that the resolution notice includes: all information considered in investigating the grievance; findings and conclusions based on the investigation; and disposition of the grievance. One (1) of 10 files did not meet any of these requirements; this file was missing the resolution letter from Evicore. **Member Grievance – Quality File Review Results** Nine (9) of 10 files met this requirement; 1 of 10 files did not contain sufficient information in the resolution letter (sample ID 312). **Recommendation to MCO** The MCO should have a process in place to ensure all documentation is in the file and the resolution letter contains sufficient disposition information for the member.	
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the	Deem for 2017		Includes member grievance – random and member grievance – quality file review	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor 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. 42 CFR 438.408 (c)			results.	
Appeal File Review				
Within five working days of receipt of the appeal, the Contractor shall provide the Member 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. KAR 17:010 Section 4 (10) (a) and (b)	Full - Includes grievance file review results. This requirement is addressed on page 73 under "Complaints" in "2017 Member Handbook," in the 1st 2 bullet points on page 62 of "2016 Member Handbook," in the last paragraph on page 1 and 1st paragraph on page 2 of "Rights Backer-Sample.doc," in the 4th paragraph of "Provider Complaints" on page 128 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual), in the 2nd paragraph of "Provider complaint and appeal process" on page 123 of "2016 Provider Manual.doc" (Aetna Better Health Provider Manual),in the 6th bullet on page 9 of "2016 Member Appeals – 3100.70.doc," and in the 4th paragraph on page 4 of "2016 Provider	Full	Includes member appeal file review results. The requirement to provide written notice that the appeal has been received with the expected date of its resolution is addressed in the appeal acknowledgment letter templates for written and oral appeals.	

Final Findings

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 6300.38.doc." <u>Member Appeal File Review Results</u> 10 of 10 included timely acknowledgment letters.			
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. KAR 17:010 Section 4 (7)	Deem for 2017		Includes member appeal file review results.	
The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe. KAR 17:010 Section 4 (11) and (12)	Deem for 2017		Includes member appeal file review results.	
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. 42 CFR 438.406 (b) (2)	Deem for 2017		Includes member appeal file review results.	
The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file,	Deem for 2017		Includes member appeal file review results.	

Final Findings

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**
including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate. 42 CFR 438.406 (a) (3) (4)				
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: 1) the results of the resolution process; (2) the date it was completed. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Deem for 2017		Includes member appeal file review results.	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (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.	Deem for 2017		Includes member appeal file review results.	

Final Findings

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**
42 CFR 438.408 (e) (2)				
Expedited Appeals File Review				
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. KAR 17:010 Section 4 (14) (c)	Full - Includes review results for Member Appeals. This requirement is addressed on page 75 under "Expedited appeals" in "2017 Member Handbook," in the last paragraph on page 63 in "2016 Member Handbook," in the second paragraph on page 2 of "Rights Backer-Sample.doc," in the 1st paragraph on page 131 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual), in the "Expedited appeals" section on page 126 of "2016 Provider Manual.doc" (Aetna Better Health Provider Manual), in the 2nd paragraph on page 13 of "2016 Member Appeals – 3100.70.doc." <u>Member Appeal File Review Results</u> 10 Member Appeal files were reviewed and none were expedited appeals.		Includes file review results for member appeals, if expedited.	
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	Deem for 2017		Includes file review results for member appeals, if expedited.	

Final Findings

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**
extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay. KAR 17:010 Section 4 (14) (d) and (15)				
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Full - Includes review results for Member Appeals if expedited. This requirement is addressed in 1st bullet point of "Appeal Process" on page 11 of "2016 Member Appeals," and on page 75 under "Expedited appeals" in "2017 Member Handbook." <u>Member Appeal File Review Results</u> 10 Member Appeal files were reviewed and none were expedited appeals.		Includes file review results for member appeals, if expedited.	
25.3 State Hearings for Members				
A Member may not file a grievance with the state. A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Member, or the Member's representative or legal representative of the Member's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). 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 forty-five (45) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010. A Member may request a State Fair Hearing for an	New Requirement	Full	This requirement is addressed in the Member Appeals Policy 3100.70 and the member handbook. This requirement is also addressed in the attachment to the member letter/notice of adverse determination.	

Final Findings

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**
Action taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B. 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. The contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but not later than 72 hours from the date the Contractor receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services. The Department shall provide for an expedited State Fair hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the Contractor.				
28.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that a Provider shall have the right to file an internal appeal with the Contractor regarding denial of a health care service or claim for reimbursement, provider payment or contractual	Full - Includes file review summary results for Provider Grievances and Provider Appeals.	Substantial	Includes file review results for provider grievances and provider appeals. Includes review of MCO Reports:	**Rebuttal**- We do not agree with the Substantial rating as it appears all requirements were met per the file review results.

Final Findings

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. The Contractor shall provide written notification to the Provider regarding a denial. The Department shall provide a standard Provider Grievance Form to be used by the Contractor to initiate its provider grievance process. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals. Appeals shall be recorded in a written record and logged with the following details: date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the Appeal, disposition of the Appeal, corrective action required and date resolved. Provider grievances or appeals shall be resolved and the Provider shall receive in writing the resolution 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. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall monitor and evaluate Provider Grievances and Appeals. The Contractor shall submit monthly reports to the Department regarding the number, type and outcomes including final denials of Provider Grievances and Appeals.	This requirement is addressed on page 3 and 6 of "2016 Provider Appeals 6300.38.doc," on pages 1, 2, 4 and 6 of "2016 Provider Grievances -6300.doc," on pages 128, 129, 131 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual), on pages 121 and 124 of "2016 Provider Manual.doc" (Aetna Better Health Provider Manual) on pages 5 and 6 of "Rights Backer-Sample.doc." Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) Provider Grievance File Review 10/10 were compliant Provider Appeals File Review 10/10 were compliant New Requirement		#27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) This requirement is addressed in the Provider Appeals Policy 6300.38. This requirement is also communicated in the provider manual and supported by a claims remittance example, as well as the MCO reports #27, #28 and #29. **Provider Grievance File Review** Eight (8) of 8 files met the timeliness standard (within 30 days of receipt of request). Five (5) of 8 files had an extension granted, and all 5 extensions were requested and granted by the MCO. These 5 files were designated not applicable for the requirement that the "member was provided a written notice of reason for the extension within 2 working days of the decision to extend the timeframe if member did not request the extension." Seven (7) of 8 files met the requirement for the resolution notice to include all information considered in investigating the grievance.	

Final Findings

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**
			Six (6) of 8 files met the requirement for the resolution notice to include findings and conclusions based on the investigation. Eight (8) of 8 files met the requirement for the resolution notice to include the disposition of the grievance. **Provider Appeal File Review** Ten (10) of 10 files met the timelines standard (resolution within 30 days of receipt of request). Ten (10) of 10 files met the requirement to include the nature of the appeal and the date the appeal was received. One (1) of 10 files had an extension granted, and this 1 file met the requirement for a decision within 14 days. Ten (10) of 10 files met each of the following requirements: disposition of appeal, date resolved, and written notice to provider. No corrective action was required for any of the 10 files reviewed; therefore, each was designated as not applicable for this requirement.	

Final Findings

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**
			Final Review Determination No change in determination. Based on the file review, Seven (7) of 8 files met the requirement for the resolution notice to include all information considered in investigating the grievance. Eight (8) of 8 files met the requirement for the resolution notice to include the disposition of the grievance. Therefore the file review was not fully met.	
A Provider who has exhausted the Contractor's internal appeal process shall have a right to appeal a final denial, in whole or in part, by the Contractor to an external independent third party in accordance with applicable state laws and regulations. The Contractor shall provide written notification to the Provider of its right to file an appeal. A Provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) days unless the Final Order designates a different timeframe.	Full - This requirement is addressed in 3rd paragraph of page 130 of "2017 Provider Manual.doc" (Aetna Better Health Provider Manual), and on pages 7 and 8 under "Provider External Review Process" of "Rights Backer-Sample.doc". New Requirement	Substantial	The provider appeals policy addresses the provider's right to appeal a final decision; however, neither the provider manual nor this policy specifically state that, "If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) days unless the Final Order designates a different timeframe." On site, the MCO provided the Provider Appeals Policy 6300.38 updated on 10/8/18 that does include this new language; however, this revision was effective after the review timeframe. **Recommendation for MCO** The MCO should implement the revised policy for the original policy.	Agree- The Provider Appeals Policy 6300.38 revised policy dated 10/8/18 has been updated to been finalized and in effect.
28.10 Other Related Processes				
The Contractor shall provide information specified in 42	Deem for 2017			

Final Findings

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**
CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.				
38.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.	Deem for 2017		Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results)	
The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.	<u>October 2017 Review Findings</u> Full This requirement is met in the updated policy 3100.73 Reporting Process on page 5. <u>January 2017 Review Findings</u> Non-Compliance -As noted last year, no documentation was provided to support this requirement.			

Final Findings

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**
	Recommendation for Aetna MCO should explicitly address this requirement in its policy. **Final Review Determination** No change in determination. The documents provided to not address this specific requirement. The MCO updated a policy with the specific contract language which will be able to satisfy the requirement next year.			

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Grievance System
Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	8	3	2	0
Total Points	24	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		**2.46**		

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

Reviewer Decision:

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

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

Final Findings

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings
- Maintenance of grievance records

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data
Process for evaluating patterns of grievances
Sample letters for notice of action, grievance resolution and appeal resolution

Reports

Quarterly reports of grievances and appeals (MCO Reports #27, 28 and 29)

File Review

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

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Final Findings

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**
35.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral health care 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.	Deem for 2017			
The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled with the Contractor in the prior twelve (12) month period, for the purpose of assessing the Member's health care needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief a Member is pregnant, the Member shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.	Deem for 2017		Includes HRA file review results.	
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 which includes the survey instrument for both substance use and mental health disorders. Reasonable effort is defined as at least three attempts to contact the Member with at least one of those attempts by phone. The three attempts by the Contractor may not be within the same day.	Deem for 2017		Includes HRA file review results.	

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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**
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/or any other health or community services.	Substantial - Includes HRA file review results. The current health and behavioral health status of the member is required in the policy and has been updated to request demographic info. HRA File Review Results 1/25 files had HRA completed. The 1 completed HRA did not include documentation of the member's need for care management, disease management, behavioral health services, other health or community services. Recommendation for Aetna Aetna should include documentation of the member's need for care management, disease management, behavioral health services, other health or community services. To help improve the response rate, the MCO should consider adjusting process to ensure final outreach is made for all members whose HRAs aren't completed within 15 days of their deadline. MCO Response: to reach members will include a system notification to the member services team when the member calls. The alert will let the member services team know that CM is trying to reach that member. Member services will either warm transfer the call or obtain a working phone number. The plan continues to investigate opportunities with concurrent review staff to provide earlier outreach.	Substantial	Includes HRA file review results. This requirement is addressed in Policy 7500.07 Health Risk Screening Process. The MCO uses the DMS HRA form. On-site, the MCO explained that the new "Eliza" system is an automated system that makes telephone calls, and if there is a live answer, the member is transferred to a person at the call center. The MCO also discussed how the completion rate might be improved by using text messaging, as tried for the medically frail outreach process with 66% response rate. **File Review Results** Nineteen (19) of 25 files met this requirement. The remaining 6 files did not meet this requirement, because there was no documentation of HRA outreach, either by telephone or postal mailing, in the chart. **Recommendation for MCO** The MCO should continue with their pilot testing using text messaging, monitor and document using the PDSA QI tool, and expand to other populations as successes are attained per PDSA findings.	**Agree - File Review Results Response** Upon review of the 25 files, only 2 files have no documentation of HRA outreach, either by telephone of postal mailing, in the chart. One of the 2 files had no documentation, as the member's Medicaid Eligibility was retro-added. We were unable to reach the member, as they switched MCOs. One other file had no documentation of outreach. This was prior to the development of our internal audit process, and we accept the finding there was no documentation. All other files show documentation for HRA Outreach attempts via telephone or postal mailing, in the chart. **Recommendation Response** The Health Plan will continue to work with our vendor to develop a plan to outreach members via text messaging. The goal will be to improve successful outreaches, and ultimately HRA completion rates. The Health Plan will complete reporting tools as appropriate.

Final Findings

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**
	Internal process change will allow the vendor to complete their outreach attempts and if unsuccessful, mail the unable to reach letter in order for the system to update sooner; therefore, giving the CM team more time to reach member and complete the HRQ within the contractual timeframe.			
The Contractor shall use appropriate healthcare professionals in the assessment process.	Deem for 2017			
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions, including substance use and mental health disorders.	Deem for 2017			
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.	Deem for 2017		Includes review of MCO Report #79 Health Risk Assessments (see Quarterly Desk Audit results).	
The Contractor shall, upon request, share with the Department or another MCO, if the Member is assigned to the MCO, the result of any identification and assessment of the Member's needs to prevent duplication.	New Requirement	Full	This requirement is addressed in Policy 7500.07 Health Risk Screening Process on page 5.	
The Contractor shall be responsible for the management and continuity of health care for all Members.	New Requirement	Full	This requirement is addressed in Policy 7500.07 Health Risk Screening Process on page 6.	
The Contractor shall utilize a common HRA if one is	New Requirement	Full	This requirement is addressed in Policy	

Final Findings

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**
designated by the Department.			7500.07 Health Risk Screening Process by the MCO's utilization of an HRA that meets each of the KDMS specifications on page 4. The MCO uses the DMS HRA form.	

Final Findings

Health Risk Assessment

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.75**		

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

Reviewer Decision:

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

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

Final Findings

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 (MCO Report # 79)

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

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Final Findings

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**
28.2 Provider Credentialing and Recredentialing				
The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), 907 KAR 1:672 or other applicable state regulations 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. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."** The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider or within forty-five (45) days if the Provider is providing substance use disorder services.. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**" Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Membersser before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process. If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor	New Requirement	Substantial	This requirement is partially met in policies QM53 Allied Credentialing and QM54 Practitioner Credentialing, Recredentialing. A draft version of Kentucky amendment A-KY QM54 Practitioner Credentialing, Recredentialing, updated 10/8/18 was provided for proof of the new requirement that "all relative information from the Provider or within forty-five (45) days if the Provider is providing substance use disorder services." **Recommendation for MCO** The MCO should finalize the amendment A-KY QM54 Practitioner Credentialing, Recredentialing.	Agree- The revised Policy Amendment A-KY QM54 Practitioner Credentialing, Recredentialing has been finalized and in effect. A-KY QM 54 Practitioner Credent

Final Findings

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**
will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider enrollment data elements to the Department. A Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department. The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				
Appendix J				
This documentation shall include, but not be limited to:	Deem for 2017			
defining the scope of providers covered,	Deem for 2017			
the criteria and the primary source verification of information used to meet the criteria,	Deem for 2017			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Deem for 2017			
The Contractor shall have a process for receiving input from participating providers regarding credentialing	Deem for 2017			

Final Findings

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**
and recredentialing of providers.				
Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.	Deem for 2017			
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.	Deem for 2017			
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.	Deem for 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. The 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.	Deem for 2017			
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.	Deem for 2017			
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 205.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.	Deem for 2017			
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;	Deem for 2017			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Deem for 2017			

Final Findings

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**
C. A review of the credentialing policies and procedures by the formal body;	Deem for 2017			
D. A credentialing committee which makes recommendations regarding credentialing;	Deem for 2017			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Deem for 2017			
F. Written procedures for the termination or suspension of Providers; and	Deem for 2017			
G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Deem for 2017			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Full - Includes Credentialing file review summary results. This requirement is addressed in the SAM Monthly Sanction Review and Reporting Process User Guide. <u>Credentialing File Review Results</u> Ten (10) initial credentialing files were reviewed. 10/10 files were timely and contained all requirements. Aetna provided a screenshot of their credentialing system which shows a review of SAM.gov as a part of their ongoing monitoring process.		The contractor shall meet requirements under KRS.	

Final Findings

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**
	Recommendation for Aetna Since no written notification dates were available in the online tracking system, MCO should consider adding this date to track in the credentialing system. MCO Response: Please expound on what is meant by written notification dates to be tracked in the credentialing system. What dates is this referring to please?			
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Deem for 2017			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Deem for 2017			
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	Deem for 2017			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Deem for 2017			
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under	Deem for 2017			

Final Findings

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**
twenty-one (21) years of age;				
F. Previous five (5) years work history;	Deem for 2017			
G. Professional liability claims history;	Deem for 2017			
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;	Deem for 2017			
I. Current, adequate malpractice insurance, as verified through attestation;	Deem for 2017			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Deem for 2017			
K. Documentation of curtailment or suspension of medical staff privileges;	Deem for 2017			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Deem for 2017			
M. Documentation of censure by the State or County professional association;	Deem for 2017			
N. Most recent information available from the National Practitioner Data Bank;	Deem for 2017			
O. Health and Human Services Office of Inspector General (HHS OIG); and	Deem for 2017			
P. System for Award Management (SAM).	Full - This requirement is addressed in			

Final Findings

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 SAM Monthly Sanction Review and Reporting Process User Guide. Aetna provided a screenshot of their credentialing system which shows a review of SAM.gov as a part of their ongoing monitoring process. During file review, MCO showed where this is documented.			
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;	Deem for 2017			
B. Lack of present illegal drug use;	Deem for 2017			
C. History of loss of license and felony convictions;	Deem for 2017			
D. History of loss or limitation of privileges or disciplinary activity;	Deem for 2017			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Deem for 2017			
F. Applicants attest to correctness and completeness of the application	Deem for 2017			
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				

Final Findings

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**
A. National practitioner data bank, if applicable;				
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Deem for 2017			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Deem for 2017			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Deem for 2017			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Deem for 2017			
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.	Deem for 2017			
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:	Deem for 2017		The contractor shall have formalized recredentialing.	
A. A current license to practice;	Deem for 2017			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Deem for 2017			
C. A valid DEA number, if applicable;	Deem for 2017			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Deem for 2017			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Deem for 2017			
F. A current signed attestation statement by the applicant regarding:	Deem for 2017			
1. The ability to perform the essential functions of the position, with or without accommodation;	Deem for 2017			
2. The lack of current illegal drug use;	Deem for 2017			
3. A history of loss, limitation of privileges or any disciplinary action;	Deem for 2017			
4. Current malpractice insurance;	Deem for 2017			
5. Health and Human Services Office of Inspector General (HHS OIG);	Deem for 2017			
6. System for Award Management (SAM).	Full - This requirement is addressed in the SAM Monthly Sanction Review and Reporting Process User Guide. Aetna			

Final Findings

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**
	provided a screenshot of their credentialing system which shows a review of SAM.gov as a part of their ongoing monitoring process. During file review, MCO showed where this is documented.			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Deem for 2017			
A. The national practitioner data bank;	Deem for 2017			
B. Medicare and Medicaid;	Deem for 2017			
C. State boards of practice, as applicable; and	Deem for 2017			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Deem for 2017			
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.	Deem for 2017			
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulatory bodies, including the Department,	Deem for 2017			

Final Findings

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**
and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.				
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.	Deem for 2017			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Deem for 2017			
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.	Deem for 2017			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Deem for 2017			
29.1 Network Providers to be Enrolled				
The Contractor shall maintain, by written agreements, a network of Providers that consider the geographic location of Providers and its Members, the distance, travel time, the means of transportation ordinarily	Full - The MCO submitted documentation that addresses this requirement and meets this requirement for each region where the			

Final Findings

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**
used by its Members, whether the location provides physical access for its Members with disabilities, and considers the numbers of network Providers who are not accepting new Medicaid patients. 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 or as amended 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) and one (1) Rural Health Clinic into its network for each region where available 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, psychiatrists advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech language pathologists, physical therapists, occupational therapists, private duty nursing agencies, pharmacies, durable medical	provider type is available, except the MCO could not produce documentation during the review time period for the new requirement for language pathologists and substance abuse and chemical dependency providers. Recommendation for Aetna The MCO should add reports to include documentation of the new requirements for language pathologists and substance abuse and chemical dependency providers. MCO Response**:** The Health Plan accepts this recommendation.			

Final Findings

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**
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 shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavioral Health Services Organizations, Certified Family, Youth and Peer Support Providers, Licensed Clinical Social Workers, Targeted Case Managers, Chemical Dependency Treatment Centers, Residential Crisis Stabilization Units, Licensed Clinical Alcohol and Drug Counselors, Multi-Therapy Agencies(agencies providing physical, Speech and occupational therapies which include comprehensive Outpatient Rehabilitation Facilities, Special Health Clinics, Mobile Health Services, Rehabilitation Agencies and Adult Day Health Centers) and other independently licensed behavioral health professionals. The Contractor may also enroll other providers, which meet the credentialing requirements,				

Final Findings

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**
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 enrollment forms as required by the Department. The Department will continue to enroll hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC 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 CASPER/QIES file formally known as OSCAR 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.	Deem for 2017			
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	Deem for 2017			

Final Findings

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**
require costly treatment or based upon that Provider's licensure or certification.				
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.	Deem for 2017			
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.	Deem for 2017			
29.2 Out-of-Network Providers				
The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.	Deem for 2017			
29.3 Contractor's Provider Network				
All providers in the Contractor's network shall be enrolled in the Kentucky Medicaid Program. The Contractor may enroll providers in their network who do not provide services to the fee-for-service population. Providers shall meet the credentialing standards described in the Provider Credentialing and Re-Credentialing section 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	Deem for 2017			

Final Findings

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**
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 or continue participation 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.				
29.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification,	Deem for 2017			

Final Findings

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**
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.				
29.5 Enrolling New Providers and Providers not Participating in Medicaid				
A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Network but must be enrolled in the Kentucky Medicaid Program. If a potential Provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and 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. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of transactions being accepted, suspended or denied. All documentation regarding a provider's qualifications	Deem for 2017			

Final Findings

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**
and services provided shall be available for review by the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice.				
29.6 Termination of Network Providers				
A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members.	Deem for 2017			
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three (3) business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.	Deem for 2017			
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider under this subsection within three (3) business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for the termination.	Deem for 2017			

Final Findings

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 any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider.	Deem for 2017			
B. In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the Contractor will provide all terminations monthly, via the Provider Termination Report. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Deem for 2017			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) thirty (30) days prior to the effective date of the termination or (ii) within fifteen (15) days of receiving notice.	Deem for 2017			
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Deem for 2017			
The Contractor shall notify any Member of the Provider's termination provided such Member has	Deem for 2017			

Final Findings

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**
received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.				

Final Findings

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	0	1	0	0
Total Points	0	2	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

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

Final Findings

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**
28.3 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, , FQHC look-alike 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.	Deem for 2017			
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs including for a Member who has a gynecological or obstetrical health care need, a disability, or chronic illness. 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.	Deem for 2017			
The Contractor shall monitor PCP's actions to ensure				

Final Findings

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**
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;				
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;	Deem for 2017			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Deem for 2017			
D. Discussing Advance Medical Directives with all Members as appropriate;	Deem for 2017			
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;	Deem for 2017			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Deem for 2017			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Deem for 2017			
Maintaining formalized relationships with other PCPs to refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend the hours of service of their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Deem for 2017			
The Contractor shall ensure that the following acceptable	Deem for 2017			

Final Findings

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**
after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable	Deem for 2017			
(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;	Deem for 2017			
(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	Deem for 2017			
(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.	Deem for 2017			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Deem for 2017			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Deem for 2017			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Deem for 2017			
(4) Returning after-hours calls outside of thirty (30)	Deem for 2017			

Final Findings

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**
minutes.				
29.7 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 Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.	Deem for 2017			
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.	Deem for 2017			
Emergency medical and behavioral health services shall be made available and accessible to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available and accessible within 48 hours of request. The Contractor shall provide the following:	New Requirement	Full	This requirement is addressed in the provider manual on page 33 that states providers are required to ensure that access to care is provided 24 hours a day, 7 days a week.	
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Member residence 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.	Deem for 2017		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	

Final Findings

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**
B. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.				
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department; and include sufficient pediatric specialists to meet the needs of Members younger than 21 years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care.	New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This is addressed in the review of the MCO GeoAccess reports, Aetna Network Adequacy report provided by DMS dated 6/29/2018, and in the provider manual on page 31.	
D. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Deem for 2017			
E. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes, except in non-urban areas where access may not exceed sixty (60) miles or (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.	Deem for 2017		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and 48 hours for urgent care.	New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the review of the GeoAccess report	

Final Findings

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**
			KY_Medicaid_May2018_Miles_Minutes_Summary and in the provider manual on page 31.	
G. Access for general vision, laboratory and radiology services shall not exceed (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight 48 hours for Urgent Care.	Substantial - Includes review of MCO Report #12A GeoAccess Network Reports, Maps (see Quarterly Desk Audit results). The following reports were reviewed: "Aetna Better Health of Kentucky - Medicaid Vision October- 2016", "Aetna Better Health of KY_Medicaid_Rpt12A_Pharmacy_Miles" and "Aetna Better Health of KY_Medicaid_Rpt12A_Pharmacy_Minutes". As found last year, these reports, including, Report 12A, do not address this requirement since laboratories and radiologists are not displayed in the documentation. <u>Recommendation for Aetna</u> It is recommended that Aetna break out its reporting of specialists by specific provider types, including but not limited to, laboratory and	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). The appointment waiting time requirement is addressed in the provider manual. The vision, laboratory and radiology standards were met based on a review of the Aetna Network Adequacy Report provided by DMS dated 6/29/2018.	

Final Findings

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**
	radiology services. MCO Response: As of January 2017, specialties are broken out by lab and radiology on the GeoAccess report. This was a recent change not reflected during the 2017 audit timeframe.			
H. Access for Pharmacy services shall not exceed Thirty (30) miles or thirty (30) minutes.	Full - Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). The MCO provided "Aetna Better Health of KY_Medicaid_Rpt12A_Pharmacy_Minutes.pdf" and "Aetna Better Health of KY_Medicaid_Rpt12A_Pharmacy_Miles" which support this requirement. New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). The pharmacy standards requirements were met based on a review of the Aetna Network Adequacy Report provided by DMS dated 6/29/2018.	
I. In addition to any Community Mental Health Center or Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program to provide out-patient, intensive out-patient, substance abuse	Full - The PDF document ("A-KY 6100.06 Network Adequacy" only shows the non-substance abuse providers. Since the MCO doesn't have information on the census of Mental Health and Substance Abuse			

Final Findings

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**
residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services.	providers in Kentucky, determining if the fifty (50%) threshold is not applicable. <u>Recommendation for Aetna</u> The MCO should include Substance Abuse providers on network adequacy reports as well as non-substance abuse providers. MCO Response: Our network consists of Mental Health and Substance Abuse providers which in unison comprise of 50% of the Medicaid enrolled providers. A substance abuse provider can be a Psychologist, BH practitioner, Mental Health provider, etc. Our system is able to have a primary provider type and a secondary specialty type. DMS' Network Adequacy Report does not identify the specialty code associated with Substance Abuse providers. There is no way to measure adequacy against the Medicaid Network Adequacy report solely based on Substance Abuse providers. <u>Final Review Determination</u>			

Final Findings

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**
	The final review determination was changed from substantial to full based on MCO response.			
J. The Department shall notify the Contractor and all other MCOs on contract with the Department when more than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Members to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective members in the Medicaid Region.	<u>October 2017 Review Findings</u> Full This requirement is addressed in the Access to Care Plan on pages 5 and 6. <u>January 2017 Review Findings</u> Non-Compliance - This requirement is not addressed in the submitted documentation. <u>Recommendation for Aetna</u> As noted last year, the MCO should address this requirement explicitly in a policy and procedure. MCO Response: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. <u>Final Review Determination</u>			

Final Findings

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**
	No change. There is no specific policy or procedure addressing this requirement.			
29.8 Additional Network Provider Requirements				
A. The Contractor shall attempt to enroll the following Providers in its network as follows:				
1. Teaching hospitals;	Deem for 2017			
2. FQHCs and rural health clinics;	Deem for 2017			
3. The Kentucky Commission for Children with Special Health Care Needs; and	Deem for 2017			
4. Community Mental Health Centers	Deem for 2017			
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.	Deem for 2017			
B. In consideration of the role that Department for Public Health, which contracts with the local health departments plays in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:				
1. Coverage of the Preventive Health Package pursuant to	Deem for 2017			

Final Findings

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**
907 KAR 1:360.				
2. Provide reimbursement at rates commensurate with those provided under Medicare.	Deem for 2017			
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Deem for 2017			
C. 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 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 the providers listed in this subsection, 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.	Deem for 2017			
29.9 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix L that demonstrates that the Contractor has an adequate network that meets the Department's standards in the Provider Program Capacity Demonstration section of this contract. The Contractor shall notify the Department, in writing, of any anticipated network changes that may impact network standards herein.	Substantial - Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). Hospital, FQHC, Family Planning, Primary Care Centers, and Laboratory access are not included in the	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement was met based on a review of the Aetna Network Adequacy Report provided by DMS dated 6/29/2018. This showed that all reported specialties met the access standard.	

Final Findings

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**
	Report 12A. Urgent Care Centers continues to have gaps in access by miles and minutes. The latest report shows gaps for all regions. The file AE_Reports_160729_Report12A_Pharmacy_Minutes.pdf" shows that 100% of urban members have access to a pharmacy within 30 minutes, and 100% of rural members have access to a pharmacy within 60 minutes. The report notes that there are no urban members in regions 1, 2, and 4. The report does not include miles. MCO provided a Vision Network Analysis, which shows that 99.9% of members have access to a dental provider within 60 miles. Radiologists were not broken out by specialty in MCO's Geo-Access reports. Data was reported in the aggregate under "Other specialty providers".			

Final Findings

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**
	The Excel file "KY Medicaid Sept 2016 Miles Minutes" embedded in the MCO's word file displays percentages of access by provider type and region for: Dentists Family Planning Clinics Federally Qualified Health Centers/Rural Health Clinics Local Health Departments Hospitals Maternity Care Physicians Community Mental Health Centers Non Physician Providers Significant Traditional Providers Other Specialty Providers Pharmacies Primary Care Providers Urgent Care Centers MCO confirmed they contract with all Community Mental Health Centers and Federally Qualified Health Centers, in Kentucky, although some members do not live within the 60-mile and 60-minute limit.			

Final Findings

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**
	Exceptions to this requirement include: -Laboratories and Radiologists are not displayed. -Gaps in access for minutes were identified for: Family Planning Clinics Maternity Care Physicians Pharmacies Urgent Care Centers -Gaps in access for miles were identified for: Family Planning Clinics Pharmacies Urgent Care Centers <u>Recommendations for Aetna</u> As recommended last year, Identified gaps in access should be addressed by Aetna. MCO Response: Gaps are identified using the DMS Network Adequacy Report. Once we receive the findings we have the opportunity to provide DMS with a monthly report on how we are resolving issues. DMS has acknowledged there are report issues on their			

Final Findings

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**
	Adequacy report and have afforded MCOs the chance to provide evidence of network adequacy. Final Review Determination No change in determination. The MCO GeoAccess report identifies gaps and the MCO should act on those findings. The MCO should review and identify any gaps before sending the report to DMS. DMS reports can be used to aid in identifying gaps, but Aetna should use their own reports to determine gaps in coverage.			
The Contractor shall update this information to reflect changes in the Contractor's Network monthly.	Deem for 2017			
29.10 Expansion and/or Changes in the Network				
If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Members, the Contractor or Department shall notify the other of this situation and within fifteen (15) business days the Contractor shall submit a corrective action plan to remedy the deficiency. Providers in the Contractor's Network who will not accept Medicaid Members shall not be included in the assessment as to whether the Contractor's Network is adequate to comply	Deem for 2017		Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results).	

Final Findings

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**
with access standards. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time-frames to correct the deficiency.				
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.	Deem for 2017			
31.1 Medicaid Covered Services				
The Contractor shall provide Covered Services in an the amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program; that are reasonably be expected to achieve the purpose for which the services are furnished; enables the Member to achieve age-appropriate growth and development; and enables the Member to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The contractor may establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable	New Requirement	Full	The requirement to provide services supporting individuals with ongoing chronic conditions is addressed in the provider manual on pages 67–68. Family planning is addressed in the Provider manual on pages 54–55.	

Final Findings

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**
regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Member's ongoing need for such services and supports, and family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning.				
The Contractor shall provide, or arrange for the provision of Covered Services to Members in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of Covered Services. 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 H 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 the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Deem for 2017			
The Contractor may provide, or arrange to provide, services in addition to the services described above, provided quality and access are not diminished, the	Deem for 2017			

Final Findings

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**
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.				
For any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be 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.	Deem for 2017			
The Contractor shall not prohibit or restrict a Provider from advising a Member 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.	Deem for 2017			
If the Contractor is unable to provide within its network necessary Covered Services, 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.	Deem for 2017			

Final Findings

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.	Deem for 2017			
33.3 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 forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c). The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the Contractor of the Member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A Member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending Provider determines that the Member is sufficiently stabilized for transfer or discharge.	New Requirement	Substantial	This requirement is partially addressed in the provider manual. However, the new contract language is not specifically detailed in the provider manual. **Recommendation for MCO** The MCO should update its policies and provider manual to reflect the new contract language.	**Agree-** MCO updated its 2019 Provider Manual to include the additional language below**. This is pending DMS approval.** The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the Contractor of the Member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A Member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending Provider determines that the Member is sufficiently stabilized for transfer or discharge. MCO also created the attached ***6300.16 Emergency Care, Urgent Care and Post Stabilization Care Policy***

Final Findings

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**
33.4 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 compliance with 42 CFR 438.114.	Deem for 2017			
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.	Deem for 2017			
31.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in this contract. 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.	Deem for 2017			
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	Deem for 2017			

Final Findings

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**
eye-glasses, provided by ophthalmologists, optometrists and opticians;				
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Deem for 2017			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Deem for 2017			
D. Maternity care for Members under 18 years of age;	Deem for 2017			
E. Immunizations to Members under 21 years of age;	Deem for 2017			
F. Sexually transmitted disease screening, evaluation and treatment;	Deem for 2017			
G. Tuberculosis screening, evaluation and treatment;	Deem for 2017			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Deem for 2017			
I. Chiropractic services;				
J. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, allow members to directly access a specialist as appropriate for the Member's condition and identified needs; and	New Requirement	Full	This requirement is addressed in the 2018 Member Handbook on page 34.	
K. Women's health specialists.	Deem for 2017			
33.6 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	Deem for 2017			

Final Findings

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**
described in Appendix H to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.				
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members less than 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.	Deem for 2017			
All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.	Substantial - The Provider Manual addresses this requirement on page 32. The Member Handbook does not address the counseling and medical services for Family Planning. Page 20 specifies "Within 30 days for counseling and medical services; within 10 days for members under 18 years of age" in reference to Behavioral Health Services. The language says that the information will be kept private, but not within the timeframe.	Substantial	This requirement is partially addressed in the Family Planning/Reproductive Health Policy on page 4. However, the member handbook does not address the counseling and medical services for family planning time requirements. **Recommendation for MCO** The MCO should include the specific language with regard to the timeliness.	**Agree-** MCO updated the 2019-member handbook to include specific timeframes. This is pending DMS approval. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Proof of Member Handbook Update_

Final Findings

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**
	Recommendation for Aetna As recommended last year, it is recommended that Aetna explicitly add the regulatory language to its Family Planning Services Policy and to its Member Handbook in addition to addressing this requirement related to Behavioral Health Services. MCO Response: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. Final Review Determination No change in determination. The majority of the requirement is addressed and as such it should be updated to include the specific time frames.			

Final Findings

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	8	2	0	0
Total Points	24	4	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

- PCP responsibilities
- Provider hours of operation and availability, including after-hours availability
- Provider program capacity requirements
- Access and availability standards
- Emergency care, urgent care and post stabilization care
- Out-of-network emergency care
- Direct access services
- Voluntary family planning
- 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
Process for addressing non-emergent ER visits
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
GeoAccess network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care

Final Findings

- Behavioral health services including mental health and substance abuse providers
- Emergency care
- Hospital care
- General dental services
- General vision, laboratory and radiology services
- Pharmacy services

Access and delivery network narrative reports (MCO Report #13)
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
Evidence of evaluation, analysis and follow-up related to non-emergent ER visits

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
21.0 Utilization Management				
21.1 Medical Necessity				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health.	Deem for 2017			
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.	Deem for 2017			
The description shall include the scope of the program;	Deem for 2017			
the processes and information sources used to determine service coverage;	Deem for 2017			
clinical necessity, appropriateness and effectiveness;	Deem for 2017			
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Deem for 2017			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Deem for 2017			
The UM program shall be evaluated annually, including an evaluation of clinical and service	Deem for 2017			

Final Findings

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**
outcomes.				
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director, the Behavioral Health Director, or the Medicaid Commissioner.	Deem for 2017			
21.2 National Standards for Medical Necessity Review				
The Contractor shall adopt Interqual for Medical Necessity, except that the Contractor shall utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual does not cover a behavioral health service, the Contractor shall adopt the following standardized tools for medical necessity determinations - for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children: Early Childhood Service Intensity Instrument (ECSII). If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the Contractor shall submit its proposed medical necessity criteria to the Department for approval, except that submissions involving medical necessity criteria will not be deemed approved after thirty (30) days. The Department may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not otherwise covered by the named criteria in the above paragraph. The Contractor will be given	Full - The requirement is addressed by Aetna Better Health of Kentucky Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria, effective 2/1/16, pages 6-7. New Requirement	Substantial	The requirement to adopt Interqual criteria is addressed in Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria; however, the new requirements that (a) submissions involving medical necessity criteria will not be deemed approved after thirty days and (b) 90 day timeframe to implement criteria that KDMS may otherwise require is not addressed. Upon onsite file review, it was noted that MCG criteria were used. Onsite, the MCO explained that Interqual has been used since March 2018, but not prior, due to an injunction filed by MCG per prior contract between the MCO and MCG. DMS confirmed that both Interqual and MCG criteria are acceptable to meet the requirement. **Recommendation for MCO** The MCO should incorporate into the Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria the relevant language regarding the new requirement for the indicated medical necessity criteria submission timeframes.	Agree – Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria has been updated to reflect the required contractual language of this section. See pages 5- 6 of policy.

Final Findings

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**
ninety (90) days to implement criteria the Department may otherwise require.				
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Deem for 2017			
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.	Deem for 2017		Includes UM file review results.	
The Medical Director and Behavioral Health 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.	Deem for 2017		Includes UM file review results.	
The clinical reason for the denial, in whole or in part, specific to the Member shall be cited.	Full - Includes UM file review results This requirement is addressed in policy A-KY 7100.05 Prior Authorization page 24 and A-KY 7200.05 Concurrent Review page 17. These documents indicate that notices will include "The specific reason for the action, customized to the members circumstances, and in easily understandable language"		Includes UM file review results.	

Final Findings

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**
	<u>File review</u> 10 UM denial files were reviewed onsite. 10/10 files included the clinical reason for the denial. 10/10 UM denial files were compliant with all required elements. Files included one administrative denial and nine denials for medical necessity. Extensions were appropriately managed as documented in 3/3 relevant files. MCO Response: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. Aetna Better Health of Kentucky added 1-1-17 contract language (21.3, C) and added the word "clinical" to both policies: A-KY 7100.05 Prior Authorization (pg 22); and A-KY 7200.05 Concurrent Review Inpatient (pg 16). <u>Final Review Determination</u> This determination was changed to Full after discussion with DMS that			

Final Findings

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**
	allows contract sections be addressed in the MCOs policies.			
Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.	Deem for 2017			
The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions. Post-service review requests shall be completed within fourteen (14) days or, 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, may extend up to an additional fourteen (14) days.	New Requirement	Full	Includes UM file review results. This requirement is addressed in the Member Appeals 3100.70 Policy. **File Review Results** Ten (10) out of 10 files met this requirement.	
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Deem for 2017			
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.	Deem for 2017			
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 three (3) working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and	Deem for 2017			

Final Findings

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**
Responsibilities.				
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Deem for 2017			
E. The Contractor shall have written policies to ensure the coordination of services: 1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; 2. With the services the Member receives from any other MCO; 3. With the services the member receives in FFS; and 4. With the services the Member receives from community and social support providers.	New Requirement	Full	Requirement #1 is addressed in Policy 7200.07 Discharge Planning. Requirement #2 and #3 are addressed in Policy 7000.40 Member Transition. Requirement #4 is addressed in Policy 7000.43 Coordination of Member Care.	
F. 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.	Deem for 2017			
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.	Deem for 2017			
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Deem for 2017			
The written program description shall address the	Deem for 2017			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.				
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Deem for 2017			
The UM program will be evaluated by the Department on an annual basis.	Deem for 2017		Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results).	
21.3 Adverse Benefit Determination Related to Requests for Services and Coverage Denials	Deem for 2017			
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any adverse adverse benefit determination (not just service authorization actions) within the timeframes for each type of adverse benefit determination pursuant to 42 CFR 438.210(c). The notice must explain:	Deem for 2017			
A. The adverse benefit determination the Contractor has taken or intends to take;	Deem for 2017		Includes UM file review results.	
B. The reasons for the adverse benefit determination in clear, non-technical language that is understandable by a layperson;	Deem for 2017		Includes UM file review results.	
C. The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's adverse benefit determination,	New Requirement	Non-Compliance	Includes UM file review results. Policy 7200.34 Decision Making Criteria Notification meets the requirement that this	Rebuttal- Policy 7200.34 Decision Making Criteria Notification does address the requirement that documents be provided free of charge- see page 1.

Final Findings

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**
including medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;			information be provided to the member upon request; however, it does not address the requirement that these documents be provided free of charge. The Prior Authorization Policy does address this requirement; however, this requirement refers to adverse benefit determinations related to request for services and coverage denials. Member Appeals Policy 3100.70 does address the requirement to provide documentation free of charge, as well as the reason for the denial in plain language. **File Review Results** Nine (9) out of 10 files did not meet this requirement and this requirement was not applicable to one (1) file pertinent to a non-participating provider. **Final Review Determination** No change in determination. The plan has updated the letters, which are pending DMS review; however, this does not change the file review finding that this requirement was not met during the review period.	 A-KY 7200.34 Decision Making Cri Additionally, MCO Denial letters have been updated to include notification that copies of all documents related to the adverse benefit determinations can be obtained, free of charge. **NOTE: These updated letters are pending DMS review**
D. Specific and detailed information as to why the service did not meet medical necessity, if the action related to a denial, in whole or in part, of a service is due to a lack of medical necessity;	New Requirement	Substantial	Includes UM file review results. This requirement is not addressed in the documentation provided, i.e., Prior Authorization Policy; however, the Member Appeals Policy 3100.70 does address the provision of the specific reason for the decision in plain language.	Agree – Ongoing education has been initiated with the plan's Medical directors to strengthen the specificity of the denial rationale communicated to members and providers.

Final Findings

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**
			File Review Results Eight (8) out of 10 files met this requirement. One (1) file was not applicable as it pertained to a non-participating provider. The one (1) file that did not meet this requirement did include documentation that occupational therapy was denied due to lack of progress without an explanatory narrative; however, the OT narrative described progress and challenges. **Recommendation for MCO** The MCO should provide greater specificity when indicating lack of progress in therapy as a rationale for denial.	
E. The federal or state regulation supporting the action, if applicable;	Deem for 2017		Includes UM file review results.	
F. The Member's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 CFR 438.402(b);	Deem for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in the Appeal Backer, which includes explicit instructions on how to file an appeal, as well as the member's rights pertinent to an appeal. **File Review Results** Ten (10) of 10 files met this requirement by inclusion of the Appeal Backer with the Adverse Notice Letter.	
G. The Member's right to request a State hearing after receiving notice that the adverse benefit determination is upheld;	Deem for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in the Appeal Backer.	

Final Findings

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**
			File Review Results Ten (10) of 10 files met this requirement by inclusion of the Appeal Backer with the Adverse Notice Letter.	
H. Procedures for exercising Member's rights to Appeal or file a Grievance;	Deem for 2017		Includes UM file review results.	
I. Circumstances under which expedited resolution is available and how to request it;	Deem for 2017		Includes UM file review results.	
J. 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.	Deem for 2017		Includes UM file review results.	
K. Be available in English, Spanish, and each non-English language;	New Requirement	Full	Includes UM file review results. Translation services are available according to Policy 3000.64 Compliance with Section 1557 of the Patient Protection and Affordable Care Act and the 1557 Nondiscrimination Notice. The below file review findings support this requirement as each adverse notice letter included the enclosure document "Nondiscrimination Notice" which includes instructions in multiple languages for contacting the MCO to address appeals. **File Review Results** Ten (10) out of 10 files met this requirement.	
L. Be available in alternative formats for persons with special needs; and	Deem for 2017		Includes UM file review results.	

Final Findings

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**
M. Be easily understood in language and format.	Deem for 2017		Includes UM file review results.	
The Contractor must give notice at least: A. Ten (10) days before the date of an adverse Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to five (5) days if Member Fraud or Abuse has been determined.	Deem for 2017			
B. The Contractor must give notice by the date of the adverse Action for the following:				
1. In the death of a Member;	Deem for 2017			
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);	Deem for 2017			
3. The Member's admission to an institution where he is ineligible for further services;	Deem for 2017			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Deem for 2017			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Deem for 2017			
6. The Member's physician prescribes the change in the level of medical care;	Deem for 2017			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Deem for 2017			

Final Findings

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**
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.	Deem for 2017			
C. The Contractor must give notice on the date of the adverse Action when the Action is a denial of payment.	Deem for 2017			
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.	Deem for 2017		Includes UM file review results.	
If the Contractor extends the timeframe for an appeal or expedited appeal, and the extension was not at the request of the enrollee, the Contractor must make reasonable efforts to give the Member prompt oral notice of the delay; give the Member written notice within two (2) calendar days, 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 resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.	Deem for 2017 New Requirement	Minimal	Includes UM file review results. Policy 3100.70 Member Appeals address the requirement to give the member written notice of the delay within 2 calendar days; however, this document does not address the requirement for resolution of the appeal as expeditiously as the member's health condition requires and no later than the extension expires. Onsite, the MCO explained that this language was added to the Member Appeals Policy after the review period.	Agree- MCO updated Policy 3100.70 Member Appeals has been finalized and in effect.

Final Findings

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**
			File Review Results One (1) out of 10 files had an extension granted. The extension was initiated by the MCO and the member was provided with written notice of the reason for the extension and their right to file a grievance if the member disagrees with the extension. **Recommendation for MCO** The MCO should replace the original policy with the new version that includes this language.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.	Deem for 2017			
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 benefit determination.	Deem for 2017			
21.4 Prior Authorizations				
The Department shall provide a common Prior Authorization Form for all Contractors to utilize for	Deem for 2017			

Final Findings

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**
a Provider to initiate its prior authorization process. The Contractor shall give the Provider the option to use the common form or the Contractor specific form.				

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

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	5	2	1	1
Total Points	15	4	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.22**		

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

Reviewer Decision:

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

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

Final Findings

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
Sample letter for notice of action

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
Prior Authorizations (MCO Report #59)

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
37.0 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 have a sufficient number of investigators as is necessary to detect fraud, waste and abuse.	Deem for 2017			
37.1 Program Integrity Plan	New Heading			
The Contractor shall develop in accordance with Appendix N, a Program Integrity plan for the Commonwealth of Kentucky of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to three (3) months to provide a new or revised program. This plan shall include, at a minimum:	Full - The requirement is addressed in MCO's document "Special Investigations Unit (SIU) Policies and Procedures" which the MCO uses as its Program Integrity MCO which includes provisions for preventing, identifying and investigating fraud, waste and abuse. The requirement is also addressed in MCO's document Policy 002-MCD SIU Overview. The MCO added to pages 39 and 112 of "Aetna Code of Conduct" the requirement that "the Contractor has up to six (6) months to provide a new or revised program".			
A. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract as well as all federal and state requirements and standards;	Deem for 2017			
B. The designation of a Compliance Officer who is responsible for developing and implementing	Deem for 2017			

Final Findings

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**
policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors;				
C. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Contract;	New requirement	Full	This requirement is addressed in the Compliance Officer Designation and SIU Overview policy.	
D. Effective training and education for the Contractor's Compliance Officer, senior management, employees, subcontractors, providers and enrollees for federal and state standards and requirements under the contract including; 1.Training and education regarding fraud, waste, and abuse; and 2 Detailed information about the False Claims Act (FCA), rights of employees to be protected as whistleblowers, and other federal and state laws described in Section 1902 of the Act (42 USC 1396a(a)(68));	New Requirement	Full	This requirement is addressed in the 3000.20 Compliance Training and Education policy and the 3000. 40 Deficit Reduction Act and False Claims Act Compliance Requirements policy.	
E. Effective lines of communication between the Compliance Officer and the contractor's employees;	Deem for 2017			
F. Enforcement of standards through written and publicized disciplinary guidelines;	Deem for 2017			
F. Provision for internal monitoring and auditing of the member and provider;	Deem for 2017			
G. Written procedures and an operational system that include but are not limited to the following:				

Final Findings

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**
1. Routine internal monitoring and auditing of member, provider and compliance risks by dedicated staff for the Contractor and any Subcontractor;	New Requirement	Full	This requirement is addressed in the Aetna SIU policy and procedure.	
2. Prompt investigation, response and development of corrective action initiatives to compliance risks or issues as they are raised or identified in the course of self-evaluation or audit, including coordination with law enforcement agencies for suspected criminal acts to reduce potential recurrence and ensure ongoing compliance under the contract;	New Requirement	Full	This requirement is addressed in the Compliance Corrective Action policy and the SIU policy and procedure.	
3. Provision for immediate notification to the Department's Program Quality & Outcomes Division Director and Program Integrity Division Director should any employee of the Contractor, Subcontractors or agents seek protection under the False Claims Act;	New Requirement	Non-Compliance	This requirement was not addressed. Aetna added this language to the Program Integrity Plan 2018-2019, page 21 after the review period. **Final Review Determination** No change in determination. At the onsite Aetna referenced that the Program Integrity Plan, page 21 was updated with this language. This requirement became effective with the January to June 2018 MCO contract. It was added to policy A-KY 3000.40 Deficit Reduction Act, however the document is dated 9/11/2018 which is after the review period.	**Rebuttal-** The requirement is addressed in the attached 3000.40 Policy which was in effect during the full review period. See language on page 5. A-KY 3000.40 Deficit Reduction Act and F
4. Provision for prompt reporting to the Department of all overpayments identified or recovered, specifying the overpayments due to potential fraud, in a manner as determined by the Department;	New Requirement	Full	This requirement is partially addressed in the SIU policy and procedure as it contains information regarding overpayments, however, it does not address prompt	**Rebuttal-** 3900.30 Policy and corresponding Amendment were in effect for the review period. The policy establishes specific timelines on when this reporting is due.

Final Findings

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**
			reporting to the Department. **Recommendation for Aetna** Aetna updated the Program Integrity Plan 2018-2019, page 21 after the review period and should finalize it and substitute this revised policy for the original. **Final Review Determination** This determination is changed to Full. At the onsite Aetna referenced that the Program Integrity Plan, page 21 was updated with this language. This policy referenced by Aetna was not referenced in pre-onsite documentation or discussed at the onsite. However, there is language on page 3 that "Identified overpayments are reported to applicable state or federal agencies within sixty (60) days of identification." This policy was revised on 5/7/18.	Abiding by that timeline is considered prompt reporting. A-KY 3900.30 Reporting and Retu AMA 3900.30 Reporting and Retu
5. Prompt referral of any potential fraud, waste or abuse that the Contractor identifies to the Department's program integrity unit or any potential fraud directly to the state Medicaid Fraud Control Unit in the form of an investigative report or in another manner as prescribed by the Department;;	New Requirement	Full	This requirement is addressed in the SIU policy and procedure under the section regarding Referrals to State Departments of Insurance (DOIs).	
6. Provision for network providers to report and return to the Contractor any overpayment within sixty (60) calendar days of identification and to notify Contractor in writing of the reason for the overpayment;	New Requirement	Non-Compliance	This requirement was not addressed. Aetna added this language to the Program Integrity Plan 2018-2019, page 22, however it was not in effect for the review period. **Final Review Determination**	**Rebuttal-** This requirement is addressed in 3900.30 Policy and corresponding Amendment which were in effect for the review period. See page 2 of policy- attached above.

Final Findings

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 change in determination. At the onsite Aetna referenced that the Program Integrity Plan, page 22 was updated with this language. This policy was not referenced in pre-onsite documentation or discussed at the onsite. The language in the policy referenced by Aetna is not specific to a provision for network providers to report and return overpayments.	
7. Suspension and escrow of payments to a network provider for which the Department has notified the Contractor that there is a credible allegation of fraud in accordance with 42 CFR 455.23 and report payment suspension information quarterly in a manner determined by the Department;	New Requirement	Full	This requirement is addressed in the CorpFinance Provider Holds Desktop process and quarterly Suspension and Escrow reports submitted to DMS.	
8. Prompt notification to the Department when it receives information about a change in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence or the death of the Member;	New Requirement	Full	This requirement is addressed in the Desktops Members Out of Areas Address and Date of Death Reporting.	
9. Notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor;	New Requirement	Full	This requirement is addressed in the 6100.90 Provider Network Voluntary and Involuntary Terminations policy and supported by report #69 provided to DMS on a monthly basis.	
10. Method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers have been delivered to Members and the application of such verification processes on a regular basis;	New Requirement	Full	This requirement is addressed in the Special Investigations Unity (SIU) policy and procedure under the section on Requesting a Medical Record.	

Final Findings

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**
11. Ensure all of Contractor's network providers are enrolled with the Department consistent with the provider disclosure, screening and enrollment requirements of 42 CFR 455;	New Requirement	Full	This requirement is addressed in the 6300.10 Provider Responsibilities policy.	
12. An accounts receivable process to collect outstanding debt from enrollees or providers and provide monthly reports of activities and collections to the Department in a manner determined by the Department;	New Requirement	Substantial	This requirement is partially addressed in the Provider Receivable Management Desktop that addresses the provider process for collecting outstanding debt from providers. However, a process was not found for recouping debt from members. **Recommendation for Aetna** Per Aetna, they added this to the Program Integrity Plan 2018-2019 in the Member Fraud Section on page 19 after the review period and should finalize it and substitute this revised policy for the original.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.
13. An appeal process;	New Requirement	Full	This was addressed in the Program Integrity Plan and Provider Discrepancy letter.	
14. Process for card sharing cases;	New Requirement	Non-Compliance	This requirement was not addressed. This language was added to Program Integrity Plan 2018-2019, pages 19 and 22. However it was after the review period.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.
15. Conducting a minimum of three (3) on-site visits per quarter related to investigations of fraud, waste and abuse and reporting related information to the Department in a manner determined by the Department;	New Requirement	Full	This requirement is addressed in the Aetna Tips reports that are submitted to DMS.	
16. Tracking the disposition of all member and	New requirement	Full	This requirement was not addressed.	**Rebuttal-** The document "Special

Final Findings

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**
provider cases (initial and preliminary) as well as case management that allows for ad hoc reporting or case status			Per Aetna, they added this language to the Program Integrity Plan 2018-2019, page 22, however it was not in effect for the review period. **Final Review Determination** Review determination changed to Full. At the onsite Aetna referenced that the Program Integrity Plan, page 22 was updated with this language but after the review period. This policy referenced by Aetna does contain the contract language and system to meet this requirement.	Investigations Unit Policies & Procedures" addresses this requirement on page 54.  Special Investigations Unit I
17. A prepayment review process in accordance with this contract; and	New requirement	Full	This requirement is addressed in the Prepayment Case process.	
18. Two (2) full-time investigators with a minimum of three (3) years Medicaid fraud, waste and abuse investigatory experience located in Kentucky dedicated 100% to the Kentucky Medicaid Program, and notification to the Department's Program Integrity Director if there is any absence or vacancy that is more than thirty (30) days with a contingency plan to remain compliant with the other contract requirements in the interim.	New requirement	Substantial	This requirement is partially addressed through the submission of the resumes for the 2 investigators. However, the additional contract language was not present. **Recommendation for Aetna** Per Aetna this was added to Program Integrity Plan 2018-2019, on pages 3, 4, 11. Aetna should finalize it and substitute this revised policy for the original.	Agree-Program Integrity Plan was updated and finalized 10/12/2018.
H. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Deem for 2017			
I. 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	Deem for 2017			

Final Findings

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**
were received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
J. 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 identified and collected;	Deem for 2017		Includes review of MCO Report #75 SUR Algorithms	
K. Contractor shall follow cases from the time they are opened until they are closed following written protocol regarding submission of investigative reports to the Department;	Deem for 2017			
L. Contractor shall notify Department within fifteen (15) business days in a manner determined by the Department of any provider placed on prepayment review related to fraud, waste and abuse. The information shall include at a minimum the following: 1. Case Number; 2. Provider Name; 3. Medicaid Provider ID; 4. NPI; 5. Summary of Concern; and 6. Date action taken. The Contractor shall submit an annual listing of providers that were under prepayment review during the state fiscal year in a manner determined by the Department; and	New requirement	Non-Compliance	This requirement was not addressed. Per Aetna, they added this language to the Program Integrity Plan 2018-2019, pages 22-23, however it was not in effect for the review period.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.
M. Contractor shall attend any training given by the	Deem for 2017			

Final Findings

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**
Commonwealth, Department, its Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.				
The plan shall be made available to the Department for review and approval.	Deem for 2017			
9.2 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 Contractor's enrollment or projected enrollment.				
P. A Compliance Director who shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractors and oversee the Contractor's compliance with the laws and 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.	Deem for 2017			
N. A Program Integrity Coordinator, who shall be located in Kentucky and whose job duties are dedicated exclusively to the coordination, management, and oversight of the Contractor's Program Integrity unit to reduce fraud, waste and	Full - This is addressed in MCO document Policy 3000.02 Compliance Officer Designation page 2, which states that the Compliance Officer is responsible for coordinating the day-to-day functions of the			-

Final Findings

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**
abuse of Medicaid services within Kentucky..	MCO's compliance program. MCO document Policy 002-MCD SIU Overview contains an embedded organization chart for the MCO's SIU Medicaid Team. However, the document does not show if any of the employees listed on the organizational chart act as the Program Integrity Coordinator and is located in Kentucky. MCO document ABHKY FWA Committee Charter (the document is undated) provides information on the MCO's Fraud, Waste and Abuse Committee and lists Sabrina Moore as the Compliance Officer. The MCO submitted copies of the Fraud, Waste and Abuse Committee minutes for September 2016, October 2016 and November 2016 which show that the following employee roles: Sabrina Moore, Compliance Officer and Manager of Compliance; Joe Christensen, SIU Director; Tabitha Kielb SIU Manager; Cherie Ottochian, SIU Supervisor and Dawn Demerchant, SIU Project Manager. The MCO provided an organization chart showing that staff is located in Kentucky. <u>Recommendation for Aetna</u> MCO should consider adding the new language that these positions are located in Kentucky to their policies and procedures.			

Final Findings

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**
37.2 Prepayment Review				-
The Contractor shall have policies and procedures for a prepayment review process in accordance with the requirements of this contract, and should perform a review when there is a sustained or high level of payment error or data analysis identifies a problem area. The Contractor shall have discretion on when to utilize prepayment review, but should consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area. The Contractor shall not use prepayment review to hold claims for an indefinite period of time. The Contractor shall review the documentation submitted within a reasonable amount of time to determine whether the claim should be paid. Claims under prepayment review are not subject to prompt payment or timely filing requirements.	New Requirement	Minimal	This requirement was partially addressed in the Prepayment Case Process Desktop. However, there was no policy and procedure provided that addresses this requirement in detail. **Recommendation for Aetna** Per Aetna this was added to Program Integrity Plan 2018-2019, on pages 19-20. Aetna should finalize it and substitute this revised policy for the original.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.
Notice shall be sent to the provider in writing on or before the date a prepayment review is started. The written notice shall contain the following: A. Specific reason for the review; B. Complete description of the specific documentation needed for the review and method of submission; C. Timeframe for returning the documentation, and information that the claim will be denied if documentation is not returned timely; D. Length of time the prepayment review will be	New Requirement	Minimal	This requirement was partially addressed in the Prepayment Case Process Desktop. However, there was no policy and procedure provided that addresses this requirement in detail. **Recommendation for Aetna** Per Aetna this was added to Program Integrity Plan 2018-2019, on pages 19-20. Aetna should finalize it and substitute this revised policy for the original.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.

Final Findings

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**
conducted if the Contractor has determined one at its discretion; E. Contact information if there are questions related to the prepayment review; and F. Information on how the provider may request removal of a prepayment review.				
The Provider shall be given forty-five (45) calendar days to submit documents in support of claims under prepayment review. The Contractor shall deny claims for which the requested documentation was not received by day forty-six (46). The Contractor shall deny a claim when the submitted documentation lacks evidence to support the service or code. The Contractor shall follow Contract Provision 28.9 for any appeals related to the prepayment process. The Contractor may extend the length of a prepayment review when it is determined necessary to prevent improper payments.	New Requirement	Minimal	This requirement was partially addressed in the Prepayment Case Process Desktop. However, there was no policy and procedure provided that addresses this requirement in detail. **Recommendation for Aetna** Per Aetna this was added to Program Integrity Plan 2018-2019, on pages 19-20. Aetna should finalize it and substitute this revised policy for the original.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.
38.14 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	October 2017 Review Findings Full This requirement is addressed on page 3 of the Receipt and Response to Regulatory Inquiries Policy. January 2017 Review Findings Minimal - Includes review of individual disclosures This requirement is addressed in the policy "Disclosure of Ownership Revised		Includes review of individual disclosures	

Final Findings

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**
each written request for such information:	7.2015.pdf", but similar to last year, there is no policy provided by the MCO that address provisions (1)-(5) explicitly. <u>Recommendation to Aetna</u> It is recommended that Aetna explicitly add the regulatory provisions (1)-(5) to its policy. MCO Response: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. <u>Final Review Determination</u> No change in determination. The referenced document is ADO form and not a policy. Aetna should develop a policy with regard to this contract requirement.			
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;	Full - Includes review of individual disclosures This requirement is addressed in the policy "Disclosure of Ownership Revised 7.2015.pdf".		Includes review of individual disclosures	
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 - Includes review of individual disclosures This requirement is addressed in the policy "Disclosure of Ownership Revised 7.2015.pdf".		Includes review of individual disclosures	

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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**
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 $25,000 during the immediately preceding twelve-month period;	Full - Includes review of individual disclosures This requirement is addressed in the policy "Disclosure of Ownership Revised 7.2015.pdf".		Includes review of individual disclosures	
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 - Includes review of individual disclosures This requirement is addressed in the policy "Disclosure of Ownership Revised 7.2015.pdf".		Includes review of individual disclosures	
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 - Includes review of individual disclosures This requirement is addressed in the policy "Disclosure of Ownership Revised 7.2015.pdf".		Includes review of individual disclosures	
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	Deem for 2017			
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	Deem for 2017			

Final Findings

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**
ownership including management and staff.				
State Contract, Appendix N				
ORGANIZATION: The Contractor shall establish a Program Integrity Unit (PIU) to identify Fraud, Waste and Abuse and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and on-going basis;	Deem for 2017			
B. Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable contract requirements and standards and federal and state laws, regulations and standards;	Deem for 2017 New Requirement	Full	This requirement is addressed in the Special Investigations Unit (SIU) policy and procedure on page 4.	
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with all applicable contract requirements and standards and Federal and State laws, regulations and requirements;	Deem for 2017 New Requirement	Full	This requirement is addressed In the Special Investigations Unit (SIU) policy and procedure as well as the SIU Overview policy.	
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Deem for 2017			
E. The unit prioritizes 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	Deem for 2017			-

Final Findings

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**
impact include cases involving:				
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Deem for 2017			
(2) High dollar amount of potential overpayment; or	Deem for 2017			
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Deem for 2017			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Deem for 2017			
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Deem for 2017			
H. There are a minimum of two (2) full-time investigators: (1) With a minimum of three (3) years of Medicaid fraud, waste and abuse investigatory experience (2) Located in Kentucky; and (3) Dedicated 100% to the Kentucky Medicaid Program	New Requirement	Substantial	This requirement is partially addressed through the submission of the resumes for the 2 investigators. The 2018 org chart as part of the SIU Overview document only shows 1 KY investigator. **Recommendation for Aetna** Aetna should update the organization chart to reflect the 2 investigators in Kentucky. **Final Review Determination** No change in final determination. The organization chart embedded in the MCD SIU Overview submitted pre-onsite showed only 1 investigator. The attached organization chart	**Rebuttal-** The MCO 2018 org chart provided at the time of audit reflect the 2 investigators in Kentucky. ABH KY Organizational Char

Final Findings

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 one embedded in the Program Integrity Plan submitted during the onsite does show two Kentucky Investigators, however the org chart is dated 8/31/18 which is after the review period.	
FUNCTION: Contractor and/or Contractor's PIU shall:				
A. Prevent 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.	Deem for 2017			
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Deem for 2017			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Deem for 2017			
D. Initiate appropriate administrative actions to collect overpayments;	Deem for 2017			
E. Refer potential Fraud, Waste and Abuse cases to the Department after an initial investigation for possible referral for civil and criminal prosecution and administrative sanctions , or for the	Deem for 2017			

Final Findings

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**
Department's permission to collect overpayments in excess of $500 as an administrative recoupment or for investigation or case closure;;				
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;	Deem for 2017			
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Deem for 2017			
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Deem for 2017			
I. Provide for internal monitoring and auditing of Contractor and it subcontractors; and supply the Department with reports on a quarterly basis or as-requested basis on its activity and ad hocs as necessary;	Deem for 2017			
J. Be subject to on-site reviews and fully comply with requests from the Department to supply documentation and records;	Deem for 2017			
K. Collect outstanding debt owed to the Department from members or providers; and provide monthly reports of activity and collections to the Department;	Deem for 2017		Includes review of MCO Report #71 Provider Outstanding Account Receivables	
L. Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after 180 days;	Full - The MCO addressed this requirement in policy "010 MCD Pursuing Recoveries Lost to Fraud Waste or Abuse.doc"			

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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**
M. The Contractor shall, as requested by the Department, recoup on any outstanding provider overpayments not identified by the Contractor if the provider has exhausted all appeals and the provider fails to pay the Department within sixty (60) days, and remit the amount or balance within sixty (60) days of notification by the Department;	New Requirement	Non-Compliance	This requirement was not addressed. Per Aetna, they added this language to the Program Integrity Plan 2018-2019, page 6, however it was not in effect for the review period.	Agree- Program Integrity Plan was updated and finalized 10/12/2018.
N. 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;	Deem for 2017			
O. Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;	Deem for 2017			
P. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Deem for 2017			
Q. Locally maintain 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;	Deem for 2017			
R. Designate a contact person to work with staff investigators and attorneys from the Department OIG and any other agent or contractor of the Department;	Deem for 2017			
S. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Deem for 2017			

Final Findings

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**
T. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Deem for 2017		Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB)	
U. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;	Deem for 2017		Includes review of MCO Report #75 SUR Algorithms	
V. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Full - The MCO addressed this requirement in policy "010 MCD Pursuing Recoveries Lost to Fraud Waste or Abuse.doc"			
W. Comply with the program integrity requirements set forth in the Patient Protection and Affordable Care Act, specifically 42 CFR 438.608, and all applicable requirements and standards under this contract and any federal and state laws and regulations, and provide policies and procedures to the Department for review and approval;	<u>October 2017 Review Findings</u> Full This was addressed in the A-KY 6100.90 Provider Network Voluntary and Involuntary Terminations tool #6 <u>January 2017 Review Findings</u> Minimal - The last sentence of ""010 MCD Pursuing Recoveries Lost to Fraud Waste or Abuse.doc" generally, but not explicitly, addresses this requirement: "During each part of the process, the Investigator will also need to consider state regulations regarding time periods that can be collected, extrapolations, approval, etc."			

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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**
	Recommendation for Aetna As suggested last year, the MCO should explicitly address requirement in the policy and procedure. MCO Response: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise.			
X. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Deem for 2017			
Y. Recover overpayments from providers;	Deem for 2017			
Z. Identify Providers for pre-payment review as a result of the Provider's activities in accordance with the contract;	New Requirement	Full	This requirement was not addressed. Per Aetna, they added this language to the Program Integrity Plan 2018-2019, page 6; however it was not in effect for the review period. **Final Review Determination** This determination changed to Full. At the onsite Aetna referenced that the Program Integrity Plan, page 6 was updated with this language but after the review period. This desktop procedure referenced by Aetna contains language to meet this requirement.	**Rebuttal-** Desktop 0039 explains (on page 1) that the investigator will research the plan, state, Aetna policies (CPB) and industry standards. Save any information in the SharePoint folder and document in Case Tracker. This Desktop procedure was in effect for the review period. 0039 Prepayment Case Process.doc
AA. Conduct a minimum of three (3) on-site visits per	New Requirement	Non-Compliance	Aetna did not provide any documentation to	Agree- Site visit documentation was

Final Findings

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**
quarter related to investigations of suspected fraud and abuse. The site visit shall be approved within a minimum of ten (10) calendar days by the Department;			show that they conduct 3 on-site visits per quarter or that the site visits are approved by the Department within 10 calendar days.	provided on the March 2018 and June 2018 Monthly Tips Report.
BB. Notify the Department if there is an absence or vacancy in an investigator position that is longer than thirty (30) days, and include a contingency plan to remain compliant with the contract requirements in the interim; and	New Requirement	Non-Compliance	This requirement is not addressed. This language was added to the Program Integrity Plan 2018-2019, page 6 after the review period.	Agree-Program Integrity Plan was updated and finalized 10/12/2018.
CC. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of thirty (30) calendar days or the timeframes established by Federal and state laws and regulations.	Deem for 2017			
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 with copy to the Department and OIG. . Potential Member safety issues related to investigations shall be reported in accordance with state law with a copy to the Department's Program Integrity Division Director and Program Quality & Outcomes Division Director.	Deem for 2017 New Requirement	Non-Compliance	This requirement was not addressed. Per Aetna, they added this language to the Program Integrity Plan 2018-2019, page 7 However the plan was not in effect for the review period.	Agree-Program Integrity Plan was updated and finalized 10/12/2018.

Final Findings

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 have an operational system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:				
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct an initial investigation to determine the validity of the complaint;	Deem for 2017			
B. The PIU should review background information and MIS data; however, the initial investigation should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Deem for 2017			
C. If the initial investigation results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to the Department; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments;	Deem for 2017			
D. If the initial investigation results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the, the Department;	Deem for 2017			
E. The Department will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate				

Final Findings

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**
administrative action;				
F. If in the process of conducting an initial 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 of their findings and proceed only in accordance with instructions received from the Department;	Deem for 2017			
G. If the Department determines that it will keep a case referred by the PIU to the OIG, the OIG will conduct a preliminary investigation review the PIU's report and evidence, gather additional evidence if needed, and forward information if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate action;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend and escrow Provider payments in accordance with Section 6402 (h)(2) of the	Deem for 2017			

Final Findings

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**
Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;				
K. Upon completion of the PIU's initial investigation, the PIU shall provide the Department a copy of their investigative report, which shall contain the following elements:	Deem for 2017			
(1) Name and address of subject,	Deem for 2017		Includes Program Integrity file review results	
(2) Medicaid identification number,	Deem for 2017		Includes Program Integrity file review results	
(3) Source of complaint,	Deem for 2017		Includes Program Integrity file review results	
(4) State the complaint/allegation,	Deem for 2017		Includes Program Integrity file review results	
(5) Date assigned to the investigator,	Deem for 2017		Includes Program Integrity file review results	
(6) Name of investigator,	Deem for 2017		Includes Program Integrity file review results	
(7) Date of completion,	Full - Includes Program Integrity file review results. This requirement is addressed in both Report #77 and Report #76. The MCO submitted copies of both reports for the 1st, 2nd and 3rd Quarters of 2016. <u>Program Integrity File Review Results</u> 8/10 files contain the date of completion. 2/10 files were in an active investigation at the time of the review.		Includes Program Integrity file review results	
(8) Detail as to what timeframe was reviewed;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Program	

Final Findings

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**
			Integrity Plan. **Program Integrity File Review Results** Five (5) of 10 files met this requirement. Five (5) of 10 files were not applicable.	
(9) How many member records were reviewed for that timeframe and the total of number of claims;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Program Integrity Plan. **Program Integrity File Review Results** Five (5) of 10 files met this requirement. Five (5) of 10 files were not applicable.	
(10) The issues identified;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Program Integrity Plan. **Program Integrity File Review Results** Five (5) of 10 files met this requirement. Five (5) of 10 files were not applicable.	
(11) Methodology used during investigation,	Full 0- Includes Program Integrity file review results. This requirement is addressed in both Report #77 and Report #76. The MCO submitted copies of both reports for the 1st, 2nd and 3rd Quarters of 2016. Program Integrity File Review Results 10/10 files contain the methodology used during the investigation.		Includes Program Integrity file review results	

Final Findings

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**
(12) Facts discovered by the investigation as well as the full case report and supporting documentation,	Full - Includes Program Integrity file review results, This requirement is addressed in both Report #77 and Report #76. The MCO submitted copies of both reports for the 1st, 2nd and 3rd Quarters of 2016. <u>Program Integrity File Review Results</u> 8/10 files contain the facts discovered by the investigation as well as the full case report and supporting documentation. 2/10 files did not have full case report because they were in active investigation at time of review.		Includes Program Integrity file review results	
(13) Attach all exhibits or supporting documentation,	Full - Includes Program Integrity file review results. This requirement is addressed in both Report #77 and Report #76. The MCO submitted copies of both reports for the 1st, 2nd and 3rd Quarters of 2016. <u>Program Integrity File Review Results</u> 10/10 files contain the facts discovered by the investigation as well as the full case report and supporting documentation.		Includes Program Integrity file review results	
(14) Include recommendations as considered necessary, for administrative action or policy revision,	Full - Includes Program Integrity file review results. This requirement is addressed in both Report #77 and Report #76. The MCO submitted		Includes Program Integrity file review results	

Final Findings

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**
	copies of both reports for the 1st, 2nd and 3rd Quarters of 2016. Program Integrity File Review Results 4/10 files included recommendations for administrative action or policy revision. 6/10 files did not warrant recommendations and were assigned a designation of 'Not Applicable' for this requirement.			
(15) Identify overpayment, if any, and recommendation concerning collection,	Full - Includes Program Integrity file review results. This requirement is addressed in both Report #77 and Report #76. The MCO submitted copies of both reports for the 1st, 2nd and 3rd Quarters of 2016. Program Integrity File Review Results 1/10 files identified an overpayment and contained a recommendation concerning collection. 9/10 files did not identify an overpayment, so this was "Not Applicable".		Includes Program Integrity file review results	
(16) Reason for closure of the report, if applicable;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Program Integrity Plan. **Program Integrity File Review Results** Seven (7) of 10 files met this requirement. Three (3) of 10 files were not applicable.	
(17) Request to send as a referral for a preliminary	New Requirement	Full	Includes program integrity file review results.	

Final Findings

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**
investigation for a credible allegation of fraud, if applicable; and			This requirement is addressed in the Program Integrity Plan. **Program Integrity File Review Results** Five (5) of 10 files met this requirement. Five (5) of 10 files were not applicable.	
(18) Any other elements identified by CMS for fraud referral;	Deem for 2017			
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;	Deem for 2017		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report	
M. 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	Deem for 2017			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Deem for 2017			
CASE TRACKING AND CASE MANAGEMENT (a) The Contactor shall have a case tracking and case management system to track member and provider cases; (b) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be	New Requirement	Substantial	Report #76 was provided as evidence of the case tracking system. Aetna is able to query their system for Ad hoc reporting elements. Aetna submits report #76 to DMS . However the following elements	Agree-Program Integrity Plan was updated and finalized 10/12/2018.

Final Findings

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**
able to report the following for provider cases: (1) PIU Case number, (2) Provider name, (3) Provider number, (4) NPI (if applicable), (6) Source of Complaint, (7) OIG Referral Number (if applicable), (8) MAT Case Y/N (if applicable to report), (9) Date complaint received by Contractor, (10) Date opened, (11) Name of PIU investigator assigned, (12) Summary of Complaint, (13) Justification that a referral for a preliminary investigation was not warranted based upon the evidence in the case file, (14) PIU action(s) taken and date(s), (15) Amount of overpayment if any (please note potential overpayments of $500 or more should be referred for preliminary investigation), (16) Administrative actions (if any) or referral with description, and (17) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file. (c) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for member cases:			were not reported on the report: Name of PIU investigator Supervisor attestation Per DMS, Appendix N would supersede Appendix K as Appendix N has been updated to reflect changes brought forth from the CMS Focus Review. The MCOs were notified of the changes by letter dated August 30, 2017.	

Final Findings

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**
(1) PIU Case number, (2) Member name, (3) Member number, (4) Date of Birth (if known), (5) Social Security Number (if known), (6) Source of Complaint, (7) OIG Referral Number (if applicable), (8) Date complaint received by Contractor, (9) Date opened, (10) Name of PIU investigator assigned, (11) Summary of Complaint, (12) Justification that a preliminary investigation was not warranted based upon the evidence in the case file, (13) PIU action(s) taken and date(s) within the ten (10) day review period, (14) Amount of overpayment if any, (15) Administrative actions (if any) or referral with description, (16) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file.				
REPORTING: A. The Contractor's PIU shall report on a monthly basis provider internal referrals (tips) and the disposition of the prior month's internal referrals, and on a quarterly basis in a narrative report format, as required by the Department, all activities and processes for each investigative case (for that quarter to the Department. The Contractor shall have the ability to report all aspects of a member or provider file from opening to closure) to the	New Requirement	Full	Includes review of MCO Report #76 and Report #77 Monthly TIPS reports were provided as evidence for this requirement. Reports #76 and #77 were also provided as evidence of quarterly reporting.	

Final Findings

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**
Department upon request, including overpayments identified, overpayment adjusted and recoupments of overpayments;..				
B. If any employee or subcontractor employee 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	New Requirement	Non-Compliance	This requirement was not addressed. Aetna added this language to Program Integrity Plan 2018-2019, page 10, however it was after the review period.	Agree-Program Integrity Plan was updated and finalized 10/12/2018.
C. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the Department in adherence to state requirements.	New Requirement	Non-Compliance	This requirement was not addressed. Aetna added this language to Program Integrity Plan 2018-2019, page 10, however it was after the review period.	Agree-Program Integrity Plan was updated and finalized 10/12/2018.
D. The Contractor shall adhere to all ad hoc reporting requests whether one time or recurring in accordance with Section 38.1 of this contract;	New Requirement	Full	All Ad-hoc requests come through the Plan Compliance department and are tracked through Aetna's internal database, KIT. Ad hoc requests specific to SIU also tracked and responded to via this medium.	
E. The Contractor shall report all overpayments identified as prescribed by the Department;	New Requirement	Full	This is addressed through report #76.	
F. The Contractor shall report the collection of provider overpayments and the prepayment cost avoidance in relation to the quarterly total of Monthly Benefit Payments;	New Requirement	Full	This requirement was addressed through the overpayment prepayment cost avoidance report and report #76.	
G. The Contractor shall report the escrow of provider payments in adherence to state requirements;	New Requirement	Full	This requirement was addressed through the Suspension escrow report.	
H. The Contractor shall report site visits conducted in adherence to state requirements; and	New Requirement	Full	This requirement was address through the TIPS report.	

Final Findings

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**
I. The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(1) PIU Case number;	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(2) Provider /Member name;	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(3) Provider Medicaid ID /Member Medicaid number;	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(4) Date complaint received by Contractor;	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(5) Provider NPI (if nonmember case);	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in report #76.	
(6) Source of complaint	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(7) OIG Case Number	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76 and #77.	
(8) Date complaint or referral received	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76 and #77.	
(9) Date opened	Deem for 2017		Includes review of MCO Report #76 and Report #77	

Final Findings

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**
(10) MAT related (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76.	
(11) Summary of complaint with timeframe reviewed;	Deem for 2017		Includes review of MCO Report #76 and Report #77	
(12) Initial investigation (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76.	
(13) Actions taken;	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76.	
(14) Referred to DMS (with appropriate code);	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76.	
(15) Date referred to DMS (if applicable)	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76.	
(16) Provider on prepayment (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77	

Final Findings

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 requirement is addressed in reports #76.	
(17) Overpayment identified, and	New Requirement	Full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #77.	
(18) Date case closed (if applicable).	New Requirement	full	Includes review of MCO Report #76 and Report #77 This requirement is addressed in reports #76 and #77.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Deem for 2017			
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department the OIG and any other agent or contractor of the Department;	Deem for 2017			
C. Backup, store or be able to recreate reported data upon demand for the Department the OIG and any	Deem for 2017			

Final Findings

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**
other agent or contractor of the Department;;				
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department the OIG any other agent or contractor of the Department, 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;	Deem for 2017			
E. Produce records in electronic format for review and manipulation by the Department the OIG and any other agent or contractor of the Department;;	Deem for 2017			
F. Allow designated Department staff , the OIG, and any other agent or contractor of the Department read access to ALL data in the Contractor's MIS systems;	Deem for 2017			
G. Provide the Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;	Deem for 2017			
H. Fully cooperate with the Department, the OIG any other agent or contractor of the Department, the United States Attorney's Office and other law enforcement agencies in the investigation or Fraud or Abuse cases; and	Deem for 2017			
I. Provide identity and cover documents and information for law enforcement investigators under cover.	Full - The MCO addressed this requirement in step 7 of "0009 Evidence Packages".			

Final Findings

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	40	4	3	10
Total Points	120	8	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		**2.30**		

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

Reviewer Decision:

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

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

Final Findings

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
SUR Algorithms (MCO Report #75)
Quarterly Program Integrity Reports (MCO Reports #76 and 77)
Provider Outstanding Account Receivables (MCO Report #71)
Explanation of Member Benefits (MCO Report #73)

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment				
The Contractor shall provide all Members under the age of twenty-one (21) years except those eligible pursuant to 907 KAR 4:030, 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 M. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Deem for 2017		Includes review of MCO Report #93 EPSDT CMS-416 and MCO Report #24.	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Deem for 2017			
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.	Deem for 2017			
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.	Deem for 2017			
Members and their families shall be informed about EPSDT and	Deem for 2017		Includes file review results for EPSDT	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
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.			utilization management (UM) files and EPSDT appeal files.	
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix M.	Deem for 2017			
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.	Deem for 2017			
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 shall provide treatment if the service is not available with the Contractor's Network.	Deem for 2017			
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 M.	Deem for 2017			
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible	Deem for 2017			

IPRO
Improving Healthcare for the Common Good

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MCO: Aetna Better Health of Kentucky

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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**
Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.				
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.	Deem for 2017			
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.	Deem for 2017			
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.	Deem for 2017			
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	Deem for 2017			

Final Findings

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**
education plan at school, WIC, Head Start, Department for Community Based Services, etc.				
K. Participate in any state or federally required chart audit or quality assurance study.	Deem for 2017			
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.	Deem for 2017			
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.	Deem for 2017			
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Deem for 2017			
9.2 Administration/Staffing				
I. The Contractor shall provide the functions and positions that shall be staffed by a sufficient number of qualified individuals to adequately provide for the Contractor's enrollment or projected enrollment.	New Requirement	Full	The requirement is addressed in the KY 8300.10 EPSDT Policy and supported by the job description for the combined HEDIS/EPSDT coordinator position. On site,	

Final Findings

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**
An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Coordinator, who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for Members.			The EPSDT coordinator, described her role, including EPSDT outreach for follow-up via phone.	
23.1 Required Functions				
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Full - This requirement is demonstrated in member Brochure entitled "Aetna Better Health of Kentucky." Members are directed to call 1-855-300-5528 for assistance with finding a PCP, scheduling an appointment and obtaining transportation. Linguistically appropriate material is provided. This requirement is also demonstrated in Member Handbook page 15 and pages 31-33 however it is not specifically stated that member services is available to arrange for and assist with scheduling of EPSDT services. Members are directed to member services to find out how to get care in relation to EPSDT services. Aetna also provided a screenshot of its website page Focus on Kids' Health, which advises members			

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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**
	of the EPSDT program and its components.			
38.9 EPSDT Reports				
The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter File 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.	Deem for 2017		Includes review of MCO Report #93 EPSDT CMS-416.	

Final Findings

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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	1	0	0	0
Total Points	3	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
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

Reports

EPSDT CMS-416 report (MCO Report #93)
Quarterly reports of EPSDT activities, utilization and services (MCO Report #24)

File Review

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

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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**
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in the Subcontracts section, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies			Includes review results for each subcontractor.	
1. Delegated activities and reporting responsibilities of the Subcontractor	Deem for 2017		Includes review results for each subcontractor.	
2. Subcontractor agrees to comply with all applicable Medicaid laws and regulations including applicable sub-regulatory guidance and contract provisions;	New Requirement	Full	Includes review results for each subcontractor. This requirement is addressed in the subcontractor agreements and the Service Agreement template provided by the MCO.	
3. The right of the state, CMS, HHS Inspector General, the Comptroller General or their designee to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, determination of amounts payable under the MCO's contract with the State, or for reasonable possibility of fraud or similar risk;	New Requirement	Full	Includes review results for each subcontractor. This requirement is addressed in the subcontractor agreements and the Service Agreement template provided by the MCO.	

Final Findings

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**
4. Subcontractor will make its premises, physical facilities, equipment, books records, contracts, computer or other electronic systems relating to its Medicaid enrollees available;	New Requirement	Non-Compliance	Includes review results for each subcontractor. This requirement is not addressed in the subcontractor agreements.	Agree- template has been updated. Subcontracts will be updated Q1 2019
5. The right to audit through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and	New Requirement	Non-Compliance	Includes review results for each subcontractor. This requirement is not addressed in the subcontractor agreements. The Service Agreement Template only refers to five (5) years.	Agree- template has been updated. Subcontracts will be updated Q1 2019
6. provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate	Deem for 2017		Includes review results for each subcontractor.	
B. Before any delegation, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.	Deem for 2017		Includes review results for each subcontractor.	
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.	Deem for 2017		Includes review results for each subcontractor.	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Deem for 2017		Includes review results for each subcontractor.	
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.	Deem for 2017		Includes review results for each subcontractor.	
F. The Contractor shall assure that the Subcontractor is	Deem for 2017			

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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**
in compliance with all Medicaid laws and regulations including applicable subregulatory guidance and contract provisions.				
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.	Deem for 2017		Includes review results for each 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.	Deem for 2017		Includes review results for each subcontractor	
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision	Substantial - This requirement is addressed in the Delegation Oversight Responsibilities Policy,	Substantial	This requirement is partially addressed in the Delegation Oversight	Agree- MCO has added required language in the 8000.60 Delegation Oversight

Final Findings

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**
of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member, except the Contractor shall not enter into any Subcontract with Subcontractors outside the United States. Such Subcontractors must be eligible for participation in the Medicaid program as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontractors within ten (10) days following termination.	but does not include the new language "except the Contractor shall not enter into any Subcontract with Subcontractors outside the United States". The new language in included in some of newer subcontract agreements which state: "Provider/Subcontractor acknowledges and agrees that Company is prohibited by applicable federal law from making payments to financial institutions located outside of the United States for items or services provided under a Medicaid state MCO or waiver." The MCO said that the following language in some of the older subcontract agreements in Exhibit D are being updated to include the new language and remove "Unless Aetna, in its sole discretion": "OFFSHORE SERVICES. Supplier is prohibited from using any individual or entity ("Offshore Entity") - (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Medicare Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Aetna, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Aetna's agreement, if any, shall include the terms and		Responsibilities Policy, which was updated from last year. This was also addressed in the updated Subcontractor Agreement. The requirement that 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 subcontractors within ten (10) days following termination is not addressed in the policy. The MCO submitted the following subcontractor agreements for services that involve risk-sharing, medical management, or otherwise interact with a member: 1. ACCIPIO LANGUAGE SERVICES-Language services 2. Active Health Management-Disease Mgt. 3. AKORBI- Language Service 4. Avesis-capitation dental 5. BLUEGRASS CARE NAVIGATORS-Review - CM prevent readmission 6. Caremark PCS Health, LLC-PBM 7. Center for the Study of Services-CAHPS 8. CENTRAL KENTUCKY INTERPRETER-Language services 9. Change Healthcare/Emdeon-claim intake	Responsibilities Policy to meet this requirement-. See pages 5-6 of policy.

Final Findings

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**
	conditions with which Supplier and the Offshore Entity must comply." For 2017, the MCO submitted the following subcontractor agreements: 1. MedSolutions, Inc (a.k.a. eviCore f/k/a/ Triad): UM for chronic pain 2. Prest and Associates: BH Chart reviews 3. Emdeon (a.k.a. Envoy LLC and Chamberlin Edmonds): identifies members who may qualify for SSI 4. Central KY Interpreter: Translation services 5. Avesis: Vision and dental services/benefits 6. Akorbi Translations: Translation services 7. Advanced Medical Reviews: Peer review services 8. Accipio Language: Translation services 9. Voiance – Interpretation services 10. Caremark- Pharmacy 11. Eliza Corporation – Member outreach tools 12. First Recover Group – third party recovery services 13. Health Management Systems – COB services (recovery of overpayments) 14. Trackfone – prepaid wireless service 15. Voxiva – Text message health & education messages		10. CQFLUENCY-language translation 11. DONNELLEY FINANCIAL SOLUTIONS-member kits/handbook 12. Eliza Corporation-mbr outreach tools 13. Evicore: Medsolution-capitation 14. Evicore: Triad-capitation 15. JOHN MICHAEL ASSOCIATES INC-mbr gift cards 16. MCG/Miliman-interqual review 17. MCKESSON TECHNOLOGIES LLC-interqual review 18. MICHAEL DAVID YANUCK MD-medical review 19. MICHAEL R FISHER DO PSC-medical review 20. NANTHEALTH INC aka Eviti-review 21. PATRICK J BRANDNER MD PC-medical review 22. PREST & ASSOCIATES INC-review 23. Pursuant –mbr communication 24. Red Cards-mbr cards 25. Softheon-premium vendor for waiver 26. VOIANCE LANGUAGE SERVICES LLC-language services 27. Wellpass (Lifeline) aka Voxiva-test message health and educational messages 28. Concentra Primary Care-Primary Source Verification, Committee Decision 29. Cooperative Care Physicians Hospital Organization-Primary Source Verification, Committee Decision	

Final Findings

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 Aetna Aetna should remove "unless Aetna, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Aetna's agreement" in all subcontractor agreements and include the new language explicitly in the policy. **MCO Response:** Contracts will be updated as they are renewed and repapered. Additionally, the policy language will be updated to reflect this requirement.		30. Ohio Valley Physicians Association-Primary Source Verification, Committee Decision 31. Take Care Health Systems -Primary Source Verification, Committee Decision 32. The Association of Primary Care-Primary Source Verification, Committee Decision Physicians 33. University of Kentucky-Primary Source Verification, Committee Decision 34. University of Louisville Physicians, Inc. -Primary Source Verification, Committee Decision 35. Western Kentucky Healthcare System-Primary Source Verification, Committee Decision 36. Cincinnati Children's Hospital-Primary Source Verification, Committee Decision 37. Deaconess -Primary Source Verification, Committee Decision 38. Vanderbilt-Primary Source Verification, Committee Decision 39. Kentucky Primary Care Association-Primary Source Verification, Committee Decision 40. The Physician Network-Primary Source Verification, Committee Decision 41. Norton-Primary Source Verification, Committee Decision	

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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 MCO Aetna should add language its policy that 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 subcontractors within ten (10) days following termination.	
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
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 - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
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 specifications required by this Contract;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	

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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**
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 - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
(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 - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
(2) all QAPI requirements,	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
(3) all record keeping and reporting requirements,	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
(4) all obligations to maintain the confidentiality of information,	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor	Substantial - Includes review results for each subcontractor. This requirement is included in MCO updated	Full	Includes review results for each subcontractor. This requirement is addressed in the	

Final Findings

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**
and audit operations,	policy to reference this contract section 6.0 generally, but doesn't have specific language. **Recommendation for Aetna** Aetna should explicitly include the language in the contract. **MCO Response**: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. **Final Review Determination** No Change in determination. While Aetna does specify the contract language for section 6.0, it is a large section of the contract and a more specific location should be provided.		Service Agreement Template provided by the MCO under "Access to Records."	
(6) all indemnification and insurance requirements, and	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
(7) all obligations upon termination;	Full - Includes review results for each subcontractor. This requirement is included in all subcontractor agreements.		Includes review results for each subcontractor.	
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting	Full - Includes review results for each subcontractor.		Includes review results for each subcontractor.	

Final Findings

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**
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;	The MCO submitted evidence of annual monitoring for each subcontractor to DMS on 4/16/2016. This requirement is included in all subcontractor agreements.			
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.	Full - The MCO provide a screenshot of the NCQA Website that indicates Caremark as "Certified".		Includes review results for each subcontractor.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Full - Includes review results for each subcontractor. This requirement is addressed in the Delegation Oversight Responsibilities Policy.		Includes review results for each subcontractor.	
O. The remedies up to, and including, revocation of the Subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Full - Includes review results for each subcontractor. This requirement is addressed in the MCO's subcontractor agreements.		Includes review results for each subcontractor.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Full - Includes review results for each subcontractor. This requirement is addressed in the MCO's subcontractor agreements.		Includes review results for each subcontractor.	
The requirements would be applicable to Subcontractors characterized as Risk contracts. The requirements of this section shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services	Full - The MCO did not provide the Delegation Summary report for the 2017 audit. This requirement was addressed in Audit Contract Sections 6.2 and 6.3, "State Report			

Final Findings

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**
to Members.	15_Subcontractor Monitoring".			
6.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.	Substantial - The MCO submitted four quarterly subcontractor monitoring reports to DMS. This was provided Audit Contract Section 6.2 6.3, "State Report 15_Subcontractor Monitoring" which is a PDF binder with all quarterlies on one report (NOTE: The 4th quarter report provided is for 2015 since the 2016 report hasn't been generated). The MCO referenced all of Section 6.0 in general rather than specifically including the language that the MCO informs the department of any subcontractor which provides services for the MCO and engages another subcontractor and that subcontractor earns 25k or more or 5% of the original subcontractor's operating budget. **Recommendation for Aetna** As suggested last year, the MCO should explicitly address the regulatory language and disclosure of subcontractors to DMS. **MCO Response:** DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. **Final Review Determination** No Change in determination. While Aetna does	Full	This requirement is addressed in the Delegation Oversight Responsibilities Policy on page 5.	

Final Findings

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**
	specify the contract language for section 6.3, it is a large section of the contract and a more specific location should be provided.			

Final Findings

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	4	1	0	2
Total Points	12	2	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

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

Documents

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

Reports

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

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MCO: Aetna Better Health of Kentucky

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
16.1 Encounter Data Submission				
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract.	Full - This item is addressed by the Encounter Data submission policy and the document titled 'Submitting files to the State of Kentucky'. The control log file received contains 999 acceptance rates and weekly submissions as proof of encounter data submissions to the state.			
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter identification number for each Encounter.	Full - The MCO indicates that outbound encounter records contain the Kentucky claim identification (ID). Sample data for the 837 Outbound Encounter File is provided.			
At a minimum, the Contractor shall be required to electronically provide Encounter Files to the Department, on a weekly schedule.	Full - The item is addressed by the control log file, which shows proof that the encounter files are submitted on a weekly basis.			
Encounter Files must follow the format, data elements and method of transmission specified by the Department.	Full - The document on 'Submitting files to the State of Kentucky' generalizes the process of running the encounter files, checking the files through the Kentucky Ramp Manager, and submitting approved files to DMS. The control log, which			

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	displays weekly submissions and acceptance rates, is to provide proof that files met the state's file format and data elements.			
All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) business days prior to implementation.				
The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department.	Full - The MCO provided email proof of test files and email correspondence with DMS during the audit time period.			
The electronic test files are subject to Department review and approval before production of data.				
The Contractor shall have the capacity to track and report on all Erred Encounter Records.	Full - The MCO explained that the response files from the state are compiled and put into a comprehensive inventory report. A sample rejection report which listed all error codes captured for the months of July to November was given to support this item.			
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting	Full - This requirement is addressed in "Claim Processing			

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Encounters in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounters as directed by the Department.	System Overview.docx." The MCO provided an explanation on the tool that the Health Insurance Portability and Accountability Act (HIPAA) standard codes are utilized and NPI/Provider numbers for encounters are validated daily.			
All Subcontracts with Providers or other vendors of service must have provisions requiring that an Encounter is reported/submitted in an accurate and timely fashion.	Full - The subcontract language with dental/vision (AVESIS) and pharmacy service vendors (CVS) provides proof of these vendor agreements to provide encounter data in a timely manner for the MCO to submit the requested data to the state. The MCO also addressed this requirement in the Delegation section of "CaremarkCVS Amend2 part 121815_redacted" page 127 of 200.			
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounters, and a secondary contact person in the event the primary contract person is not available.	Full - The submitter contact names were listed by the plan and an email showing they are the ones submitting the data to the state.			
16.2 Technical Workgroup				
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to	Full - Aetna meeting minutes were provided to show proof of participation. Most recent			

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter submission.	one-on-one meeting was with state on 12/14/16.			
17.0 Kentucky Health Information Exchange (KHIE)				
The Contractor shall encourage all Providers in their Network to establish connectivity with the KHIE. For newly contracted providers, the Contractor shall notify the Provider within one month of the recommendation to sign a Participation Agreement with KHIE for the purpose of connecting their electronic health records system to the health information exchange to share their patient electronic records. The data set required for submission is a Summary of Care Record.	Full - Page 31 of the MCO contract template, "Aetna Medicaid BH Prov/Group Template", meets this requirement. New Requirement	NA	This requirement is NA for 2018 since the KHIE was not available to providers during the review period. We have included the findings for informational purposes. This requirement is partially addressed on page 30 of the Provider/Group Agreement. This requirement should be included in a policy and procedure.	
For hospitals, the Contractor shall also recommend the submission of ADTs (Admission, Discharge, Transfer messages) to KHIE.	New Requirement	NA	This requirement is NA for 2018 since the KHIE was not available to providers during the review period. We have included the findings for informational purposes. This requirement was not addressed.	
If the provider does not have an electronic health record the Contractor will encourage the Provider to sign a Participation Agreement with KHIE as well as sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in their community of care.	New Requirement	NA	This requirement is NA for 2018 since the KHIE was not available to providers during the review period. We have included the findings for informational purposes. This requirement was not addressed.	
30.2 Prompt Payment of Claims				

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
In accordance with 42 CFR 447.46, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims, including I/T/Us, for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims.	Full - The 'Tool Kit-Claims Turn Around Time", "KIR #5 - KY_20170102.pdf" and "HIS_AE_Reports_161227_Report53.xls" show that 95% of clean claims resolved in 30 days, and 99% of clean claims resolved within 90 days.			
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended. The date of receipt is the date the MCO receives the claim, as indicated by its date stamp on the claim or other notation as appropriate to the medium used to file a claim and the date of payment is the date of the check or other form of payment.	Full - The MCO provided their 'Managing and Monitoring Claims Inventory Aging' process document that addresses this requirement. The MCO also provided "KIR #5 - KY_20170102.pdf" and "HIS_AE_Reports_161227_Report53.xls" which showed the plan met the Prompt-Pay Statute. New Requirement	Full	The date of receipt is addressed in the AMA 2000.20 Claims Submission Policy and the Date of payment requirement is addressed in the AMA 2000.20 Claims Submission Policy on page 2.	
The Contractor shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested.	New Requirement	Full	This requirement is addressed in policy ABH KY 7100.05 Prior Authorization Policy on page 20 under Notice of Adverse Benefit Determination Requirements.	

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MCO: Aetna Better Health of Kentucky

Quality Assessment and Performance Improvement: Health Information Systems

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems
Suggested Evidence

Documents

Policies/procedures for:

- Claims processing
- Claims payment
- Encounter data reporting

Process for verifying the accuracy and completeness of provider and vendor reported data
Process for screening data for completeness, logic and consistency
Evidence of timely and accurate reporting of encounter data to DMS
Process for monitoring compliance with claims payment timeliness requirements
Process for tracking and reporting erred encounter records
Evidence of participation in Encounter Technical workgroup
Method for meeting KHIE requirements
Status of efforts to have PCPs establish connectivity to KHIE

Reports

Timeliness of Claims Payment
Results of compliance monitoring for timeliness of claims payment and compliance with prompt pay statute
Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up

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Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
1.0 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 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				

Final Findings

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**
amount 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 a State is able to continue its 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.				
35.2 Care Management System				
As part of the Care Management System, the 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.	Deem for 2017			
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.	Deem for 2017		Includes review of MCO Report #79 Health Risk Assessments (HRAs; see Quarterly Desk Audit results).	

Final Findings

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**
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.	Deem for 2017			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Deem for 2017			
35.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Deem for 2017			
Care coordination is a process to assure that the physical and behavioral health needs of 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.	Deem for 2017			
The Contractor shall identify a Member with special physical and behavioral health care needs and shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent	Deem for 2017			

Final Findings

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**
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.	Deem for 2017		Includes review results for care coordination and complex case management files.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Deem for 2017		Includes review results for care coordination and complex case management files.	
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 services specific to the DCBS population.	Substantial - This requirement is addressed in the Aetna Better Health of Kentucky Policy A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless; Policy A-KY 7500.43 Coordination of Member Care; and Aetna Better Health of Kentucky Quality Assessment Performance Improvement Plan 2016 and QAPI Work Plan 2016. Stratification of indicators by eligibility category is documented in Report 96, Audited HEDIS Results 2016, which include Healthy Kentuckian as well as HEDIS measures. On site, staff indicated there is ongoing work on identification of foster status and care coordination for this population.	Substantial	This requirement is addressed generally, but not explicitly in the Policy A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless; Policy A-KY 7500.43 Coordination of Member Care; and in Aetna Better Health of Kentucky Quality Assessment Performance Improvement Plan 2017, which includes data on preventive care indicators stratified by eligibility category. The Excel files BH Discharge CM Activities 2017-18 and 2017 Guardianship Activities document tracking of DCBS client/guardian contact and status. On site, the MCO demonstrated an electronic database and reports that tracked DCBS client appeals, utilization via claims, pharmacy, and DME issues. The MCO also explained how grievances were addressed proactively by collaborating with DCBS. Further, in response to file review findings	Agree- MCO Policy 7500.42 Members in Foster Care, Guardianship or the Homeless has been updated to include explicit language. See page 11. As previous documentation stated, each month regional liaisons are sent a monthly email with a list of foster care members for their region. The verbiage has been changed to "Please notify Aetna Better Health of Kentucky for any care coordination needs whether or not the member is actively involved with case management. We strive to meet all members needs and can offer services such as assistance with obtaining medications, prior authorizations, obtaining DMEs, finding providers and assistance with preventative services."

Final Findings

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**
	Complaints and grievances are addressed by a designated staff member for DCBS clients. On site, staff indicated that there were very few, as they typically go to DCBS workers. Only three of twelve files in a sample of DCBS clients were in foster care in 2016. On site, staff indicated that a large proportion of members on the DCBS list were no longer in foster care, although the indicator remained. It appeared that among the sample of DCBS clients, there was evidence of outreach only in December 2016. Outreach priority was discussed with staff on site, who identified priority outreach for members who are Medically Fragile, followed by Commission for Children with Special Health Care Needs, hospital inpatient stay, and Core-identified members. (Core members include high ER usage, high inpatient admissions, and top one percent at-risk members.) Each month any new members in the above areas are outreached and assessed for case		regarding lack of care coordination for children in foster care with a **service plan with only "basic" level of care needs and no meds or other diagnoses , the MCO explained on-site that this was interpreted as an indication that there was no need for care coordination.** **<u>Recommendation for MCO</u>** **Therefore, explicit language is merited in the Policy A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless; Policy A-KY 7500.43 Coordination of Member Care to "ensure access to care coordination for all DCBS clients." In addition, a procedure to ensure implementation is warranted.**	

Final Findings

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**
	management needs. The MCO also conducts outreach for members on Difficult to Place list and those members aging out of foster care. Staff provided an example file of active care coordination for a member aging out of foster care. The MCO has also implemented additional strategies, such as tracking members in the Juvenile Justice system and outreach to families of infants with neonatal abstinence syndrome and mothers with perinatal depression. <u>Recommendation for Aetna</u> Aetna should continue to develop strategies to identify members on the DCBS list who are no longer in foster care. <u>MCO Response</u>: The foster care/adoptive list are pulled from the DMS 834 file. Aetna Better Health of Kentucky's coding reflects that of the DMS file. Aetna Better Health of Kentucky will continue to work with DMS and DCBS to improve the			

Final Findings

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**
	accuracy of the adoptive members list. Aetna Better Health of Kentucky continues to outreach adoptive member's parents when the adoptive parent contact information is provided by DCBS. We plan to share the lists with DMS. The plan is open to strategy sessions to improve this process.			
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.	Deem for 2017			
36.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, 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	Deem for 2017			

Final Findings

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**
are further identified.				
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.	Deem for 2017			
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.	Deem for 2017			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: A. Children in/or receiving Foster Care or adoption assistance; B. Blind/Disabled Children under age 19 and Related Populations eligible for SSI; C. Adults over the age of 65; D. Homeless (upon identification); E. Individuals with chronic physical health illnesses; F. Individuals with chronic behavioral health illnesses; G. Children receiving EPSDT Special Services.	Deem for 2017			
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.	Deem for 2017			

Final Findings

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**
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Deem for 2017			
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	Deem for 2017			
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.	Deem for 2017			
36.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN. The Contractor shall attempt to obtain the service plan which will be completed by DCBS or DAIL. The service plan will 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 and Adult Guardianship Cases shall be sent to Department thirty (30) days after the end of each month.	Substantial - Includes review results for DCBS Service Plan and DCBS Claims/Case Management files This requirement is addressed in Policy and Procedure A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless page 3 and 4; Policy and Procedure 7000.43 Coordination of Care and Policy and Procedure 7000.05 Integrated Care Management. The Service Plan list submitted by the MCO indicates that service	Minimal	Includes review results for DCBS service plan and DCBS claims/case management files. This requirement is addressed in Policy A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless; Policy 7000.43 Coordination of Care. The MCO provided Excel spreadsheets that support monitoring of DAIL and foster care service plans. **DCBS service plan and DCBS claims/case management file Results** Five (5) of 10 files documented ongoing care coordination. Five (5) of 10 files were without documentation of ongoing care	REBUTTAL Permission must be obtained from the DCBS worker prior to obtaining any information on a foster care child. The outreach process to DCBS is extensive. The barriers to the outreach process were discussed on site. See foster care outreach job aid:  Foster Care Outreach Process20

Final Findings

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**
	plans are not obtained for all cases. The MCO has notified DCBS and DAIL of regions that have had a minimal response to monthly service plan requests as per onsite staff. The MCO provided email evidence of monthly reports of Foster Care and Adult Guardianship Cases while on site. <u>DCBS Service Plan file review</u> There were 4/12 files provided for review on site; 1 of these files was for a member who was no longer in foster care. The remaining cases in the selected sample, for which files were not provided, were comprised of members who were determined to no longer be in foster care, mostly because of adoption as per MCO staff. All relevant information available for the remaining files was requested by the reviewer while on site. Of the 3 files in foster care during 2016, 1/3 included evidence of outreach due to the antipsychotic drug list and 1/3 for discharge from residential setting. The		coordination. Three (3) of 10 files were referred to Case Management. Of the 7 not referred to Case Management, only 2 had care coordination. Two (2) of these 3 files referred to Case Management documented coordination for care planning; 1 of 3 files referred to Case Management documented consultation with DCBS staff before development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan. Ten (10) of 10 files had claims for preventive visits. Nine (9) of 10 files had claims for EPSDT services, and the 1 file without a claim for EPSDT services had documentation of outreach for EPSDT services. **<u>Recommendation for MCO</u>** The MCO should target all children in foster care for ongoing care coordination with outreach attempts conducted monthly in order to proactively identify opportunities for preventive care and ongoing identification and management of new care needs. The MCO should not rely on the DCBS Service Plan as a tool to identify children's physical, behavioral and	With every outreach to a liaison /DCBS worker all efforts are made to obtain an HRA. The HRA is extensive and will highlight any care coordination needs. As noted in a previous conversation with a DCBS worker, children with no medications and/ or therapies are in DCBS care due to parental inabilities. Consistent outreach each month was not necessary. (This would cause further work for the DCBS system that is already at maximum capacity.) **Per the contract Section 36.4 page 125:** "If the DCBS service plan identifies the need for case management or DCBS staff requests case management for an Enrollee, the Contractor's staff will work with foster parent and/or DCBS staff to develop a case management plan" "The Contractor's staff will consult with DCBS staff before the development of a new case management plan (on a newly identified health care issue) or modification of an existing case management plan. " .

Final Findings

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**
	remaining file of the three demonstrated outreach by DCBS to the MCO for assistance with service authorization. DCBS worker was advised to contact the MCO as needed, but there was no further outreach for coordination noted in the documentation from DCBS or from the MCO. 1/3 included evidence of robust, ongoing care coordination and demonstrated coordination with DCBS and the foster caregiver. This member was identified in May of 2016; the other two members were identified late in the year. 1/3 files included documentation of discussion between the Case Manager and DCBS regarding member issues and needs, but no subsequent contact or coordination was evident in the file, and the third file included evidence of initial care coordination without ongoing coordination. 0/3 members were referred to case management and none of the files identified a need for case management.		support needs, but instead, should conduct the comprehensive needs assessments (CNAs) and generate plans of care. The plan of care is recommended as a tool to facilitate ongoing care coordination, including individualized goal setting, ongoing updating of member status in terms of whether or not goals have been met, and collaboration with DCBS to revise the plan of care when goals are not met. **Final Review Determination** No change in determination. The contract language cited in the MCO's response refers specifically to a case management plan to be developed in collaboration with DCBS in response to DCBS' request in the Service Plan; however, this contract language does not restrict foster children's receipt of initial needs assessment, care plan development and ongoing MCO care coordination to those children with such a DCBS Service Plan request. Lack of a DCBS Service Plan and/or lack of DCBS request for Case Management would not preclude a foster care child's receipt of an MCO clinical needs assessment; MCO care plan, MCO care coordination, and MCO case management. Contract Section 36.2 states, "The Contractor shall develop and implement policies and procedures to ensure access to	

Final Findings

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**
	0/3 files included service plans, although all three files of children in foster care demonstrated evidence of ongoing MCO attempts to obtain a service plan. One file of a member no longer in foster care as of December 2016, which was provided with the three files of members who were in foster care, had evidence of care coordination during 2016. Since the member was no longer a DCBS client, care management was transferred to another care manager. This file demonstrated active care coordination with the adoptive mother, including ensuring PCP, resources, coping skills and warning signs, as well as nurse line information. Of the remaining files of children no longer in foster care that were reviewed when provided, 4/6 members were documented as no longer in foster care in December 2016. Dates of adoption were not identified in the files. 2/6 cases were "closed" in December 2016, although there was no evidence of earlier		care coordination for all DCBS and DAIL clients." Section 36.4 states, "No less than quarterly, Contractor's staff shall meet with DCBS staff to identify, discuss and resolve any health care issues and needs of the Contractor's Foster Care membership." Section 36.2 also states, "Members who are adult guardianship clients or foster care children shall be identified as ISHCN" and Section 35.3 states, "The Care Plan shall be developed in accordance with 42 C.F.R. 438.208." The following was excerpted from Federal regulation 42 C.F.R. 438.208: "Each MCO must implement mechanisms to comprehensively assess each Medicaid enrollee…having special health care needs". The Comprehensive Needs Assessment due to all ISHCN is used to inform the development of a Care Plan and ongoing Care Coordination, per the below definitions excerpted from the first section of this tool: 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. Care Coordination means the integration of **all processes** in response to a Member's needs and strengths to ensure the	

Final Findings

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**
	outreach in files for the review period 2016. <u>DCBS Claims/Case Management File review</u> 4/10 claims files reviewed included evidence of well visits/EPSDT visits. 2/3 claims files of members in foster care had evidence of well visit/EPSDT visit. 1/3 claims files did not have evidence of a well visit/EPSDT visit, although care management notes indicate a reported visit in November 2015. Outreach strategies were discussed with staff on site. Staff identified priority outreach for members who are Medically Fragile, members followed by Commission for Children with Special Health Care Needs, members with hospital inpatient stay, and Core-identified members. (Core members include high ER usage, high inpatient admissions, and top one percent at-risk members.) Each month any new members in the above areas are outreached and assessed for case management needs, as per MCO		achievement of desired outcomes and the effectiveness of services.	

Final Findings

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**
	staff. The MCO also conducts outreach for members on the Difficult to Place list and those members aging out of foster care. Staff provided an example file of active care coordination for a member aging out of foster care. The MCO has also implemented additional strategies, such as tracking members in the Juvenile Justice system and outreach to families of infants with neonatal abstinence syndrome and mothers with perinatal depression. The MCO has worked to identify members currently in foster care, but it was evident from some of the files that multiple outreach attempts to DCBS was necessary to identify whether or not the member was still in foster care. The MCO provided evidence of a large proportion of members on the DCBS list that were no longer in foster care. The MCO continues to meet monthly with DCBS to discuss			

Final Findings

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**
	cases as described above. The MCO sent a survey to DCBS workers in each region in 2016 to identify opportunity for improvement for members in each region. The MCO indicated that reminders for EPSDT services are sent to a central address for children in foster care. **Recommendation for Aetna** Aetna should continue to develop strategies for timely identification of members on the DCBS list who are no longer in foster care and ongoing care coordination for members in foster care. Outreach strategies for members other than those on existing priority lists should be investigated; for example, criteria in the Core risk model could be reevaluated to ensure inclusion of at risk members. **Recommendation for DMS** DMS should continue to facilitate attempts to reconcile DCBS and MCO lists of members in foster care.			

Final Findings

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 Response: Aetna Better Health of Kentucky will continue to collaborate with DMS/DCBS to improve the identification of the adoptive members. Outreach and coordination of care continues to be offered to the adoptive member's in which contact information has been provided to Aetna Better Health of Kentucky by DCBS. The existing priority lists will continue to be outreached. Aetna Better Health of Kentucky will also outreach members with multiple diagnosis, behavioral and medical inpatient admissions and those with numerous ER visits. Aetna Better Health of Kentucky will also assess the foster care list and note any trends and outreach those members for coordination of care services. Historically, the contact information for foster parents of the foster children is not available to the MCO. The MCO must first outreach the regional worker and then the case worker information to get the foster parent information.			
36.3 Adult Guardianship Clients				

Final Findings

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**
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 determine what level of case management is needed.	Full - This requirement is addressed in policy Aetna Better Health of Kentucky Policy A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless. The requirement is also addressed in quarterly DAIL meeting notes, Guardianship Coordination of Care and Outreaches Report and Dynamo Case Rounds Reports. The MCO provided the service plan lists for Guardianship members; requests are sent monthly. Care management outreaches to DAIL for all members with need for case management indicated in service plans. Dynamo case rounds reports and DAIL meeting minutes provide evidence of discussion and coordination.			
36.4 Children in Foster Care				
No less than quarterly, Contractor's staff shall meet with DCBS staff to identify, discuss and resolve any health care issues and needs of the Contractor's Foster Care membership. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and	Full - This requirement is addressed in monthly meeting minutes provided by the MCO documenting meetings with DCBS for each month in 2016, other than the March meeting			

Final Findings

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**
specialty care providers are enrolled in the Contractor's Network.	that was canceled. A list of members discussed is also evident in the MCO's case management record system Dynamo Case Rounds reports for 2016.			
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the Contractor's staff will work with the foster parent and/or DCBS staff to develop a case management plan.	Full - This requirement is addressed in Aetna Better Health of Kentucky Policy and Procedure A-KY 7500.42 Members in Foster Care, Guardianship or the Homeless and Policy and Procedure 7500.43 Coordination of Care Services. There were no applicable files reviewed.		Includes review results for DCBS service plan files.	
The Contractor's staff will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	Full - Includes review results for DCBS Service Plan files This requirement is addressed in policy 7500.42 Members in Foster Care, Guardianship or the Homeless page None of the reviewed files included a case management care plan or need for case management, although 3/3 files included discussion of member		Includes review results for DCBS service plan files.	

Final Findings

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**
	needs with DCBS staff.			
The designated Contractor staff will sign each service plan made available by DCBS 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 Department representative.	Full - This requirement is addressed in the Aetna Better Health of Kentucky policy 7500.42 Members in Foster Care, Guardianship or Receiving Adoption Services or the Homeless.			
The Contractor shall notify the Department and DCBS no later than three (3) business days prior to the decertification of a foster child for services at a hospital or other residential facility located in Kentucky and no later than seven (7) business days prior to the decertification of a foster child for services at a hospital or other residential facility located out of state. Written documentation of an upcoming medical necessity review does not qualify as a decertification notification. The Department shall provide the Contractor with the office or division, the individual(s) and the contact information for such notification and provide updated contact information as necessary.	New Requirement	Full	This requirement is addressed in Aetna policy 7500.42 - Members in Foster Care, Guardianship or the Homeless. In addition, the BH Discharge CM Activities excel file for July 2017-June 2018 provided evidence of monitoring DCBS outreach for members in foster care with BH hospitalization.	
The decertification notification shall include: A. the Member name, B. Member ID, C. facility name, D. level of care, E. discharge plan and F. date of next follow-up appointment.	New Requirement	Full	This requirement is addressed in Aetna policy 7500.42 - Members in Foster Care, Guardianship or the Homeless.	

Final Findings

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**
If the Contractor fails to notify the Department and DCBS at least three (3) business days or seven (7) business days, as applicable, prior to the decertification and the foster child remains in the facility because arrangements for placement cannot be made, the Contractor shall be responsible for the time the foster child remains in the facility prior to notification and up to three (3) business days or seven (7) business days, as applicable, after notification.	New Requirement	Full	This requirement is addressed in Aetna policy 7500.42 - Members in Foster Care, Guardianship or the Homeless.	
The Contractor shall require in its contracts with Providers that the Provider provides basic, targeted or intensive case management services as medically necessary to foster children who are discharged from a hospital or other residential facility. The Contractor, case manager and Provider shall participate in appropriate discharge planning, focused on ensuring that the needed supports and services to meet the Member's behavioral and physical health needs will be provided outside of the hospital or other residential facility.	New Requirement	Full	This requirement is addressed in Aetna policy 7500.42 - Members in Foster Care, Guardianship or the Homeless.	
33. 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.	Full - This requirement is addressed in the Aetna Better Health of Kentucky Policy #7500.43 - Coordination of Care Services and Policy # 7500.42- Members in Foster Care, Guardianship or the Homeless. Passport provided a list of two providers who perform this service, both in Louisville. The			

Final Findings

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 has conducted outreach to attempt to identify additional providers. They have identified no access issues related to this service.			
33.8 Pediatric Interface				
School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.				
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. 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 to eligible Members.	Deem for 2017			
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-	Full - This requirement is addressed in Policy and procedure #7500.43 - Coordination of Care Services.			

Final Findings

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**
threatening/terminal illnesses.	The MCO provided a claims query for providing evidence that none of these services were billed for pediatric members. However, these services simultaneously provided by the MCO are not audited and would not be denied.			
38.11 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.	Deem for 2017		Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results).	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	4	1	1	0
Total Points	12	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		**2.50**		

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

Reviewer Decision:

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

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

Final Findings
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
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and services 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 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

Reports of service plan reviews conducted for DCBS and DAIL clients (MCO Reports #65 and 66)
HRAs (MCO Report #79)

File Review

Care Coordination and Complex Case Management files for a random sample of cases selected by EQRO
DCBS Service Plans and DCBS Claims/Case Management files for a random sample of cases selected by EQRO

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Final Findings

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**
23.7 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.	Deem for 2017			
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.	Deem for 2017			
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:	Deem for 2017			
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Deem for 2017			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Deem for 2017			
C. Consent for or refusal of treatment and active participation in decision choices;	Deem for 2017			
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Deem for 2017			
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;	Deem for 2017			

Final Findings

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**
F. Timely access to care that does not have any communication or physical access barriers;	Deem for 2017			
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Deem for 2017			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Deem for 2017			
I. Timely referral and access to medically indicated specialty care; and	Deem for 2017			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Deem for 2017			
K. Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to receive services from that provider if part of Contractor's network.	Full - The MCO included the Contract language verbatim on page 4 of the Member Rights and Responsibilities policy (4500.35).			
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Deem for 2017			
B. Abide by the Contractor's and Department's policies and procedures;	Deem for 2017			
C. Become informed about service and treatment options;	Deem for 2017			
D. Actively participate in personal health and care decisions, practice healthy life styles;	Deem for 2017			
E. Report suspected Fraud and Abuse; and	Deem for 2017			

Final Findings

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**
F. Keep appointments or call to cancel.	Deem for 2017			
23.2 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. With the exception of a new Member assigned to the Contractor, the Contractor is in compliance with this requirement if the Member's handbook is: A. Mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member. B. Provided by email after obtaining the Member's agreement to receive the information by email; C. Posted on the Contractor's website and the Contractor advises the Member in paper or electronic form that the information is available on the internet and includes the internet address, provided that Member's with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or D. Provided by any other method that can reasonably be expected to result in the Member receiving that information.	New Requirement	Full	These requirements are addressed in the following: A. A-KY 4500.15 New Existing and Reinstated Member Information Policy. B. Member Welcome Letter C. Member postcard and welcome letter as well as the Nondiscrimination notice, which includes written information about large print, audio, accessible, and other formats. D. Member kit.	
For any new Member assigned to the Contractor, the Contractor shall mail a hard copy of the Member Handbook within five (5) business days of notification of the assignment.	New Requirement	Full	This requirement is addressed in the new member welcome letter that states the member will receive the member handbook within 7 days (equivalent to 5 business days).	

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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**
If the information is provided electronically, it must be in a format that is readily accessible, is placed in a location on the website that is prominent and easily accessible, can be electronically retained and printed, and that the information is available in paper form without charge upon request within five (5) business days.	New Requirement	Full	This requirement is addressed in the A-KY 4500.15 New Existing and Reinstated Member Information Policy.	
The Member Handbook shall be available in English, Spanish and each prevalent non-English language.	Deem for 2017 New Requirement	Full	This requirement is addressed in the 4500.25 Interpreter and Translation Services Policy.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full - Includes review of online Member Handbook to confirm posting of current handbook. The MCO has included the 2016 Member Handbook, in both English and Spanish, on its Member website. https://www.aetnabetterhealth.com/kentucky/members/handbook		Includes review of online member handbook to confirm posting of current handbook.	
The Contractor shall review the handbook at least annually and shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers, covered services and any service not covered by the Contractor because of moral or religious objections. Contractor shall communicate any changes to Members in written form at least thirty (30) days before the intended effective date of the change. 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.	New Requirement	Full	This requirement is addressed in the member handbook on page 11.	

Final Findings

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 handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Deem for 2017			
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;	Deem for 2017			
B. How to access a list of network providers for covered services in paper form, upon request, or electronic form containing information required in 42 CFR 438.10(h);	New Requirement	Full	This requirement is addressed in the member handbook on page 19.	
C. Any restrictions on a Member's freedom of choice among network providers;	New Requirement	Full	This requirement is addressed in the A-KY 4500.03 PCP Assignments and Changes after Initial Enrollment Policy.	
D. The procedures for selecting a PCP and scheduling an initial health appointment or requesting a change of PCP and specialists; reasons for which a request may be denied; and reasons a Provider may request a change;	Deem for 2017 New Requirement	Full	This requirement is addressed in the member handbook and in the A-KY 4500.03 PCP Assignments and Changes after Initial Enrollment Policy.	
E. The availability of oral interpretation services for all languages, written translations in English, Spanish, and each prevalent non- English language as well as for the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services;	New Requirement	Full	This requirement is addressed in the member welcome letter.	

Final Findings

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**
F. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;	Deem for 2017			
G. 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;	Deem for 2017			
H. Member rights and responsibilities including reporting suspected fraud and abuse;	Deem for 2017			
I. Procedures for obtaining Emergency Care and non-emergency care after hours, what constitutes an emergency medical condition, the fact that a prior authorization is not required for emergency services and the right to use any hospital or other setting for emergency care. For a life-threatening situation, instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Deem for 2017 New Requirement	Full	This requirement is addressed in the member handbook on pages 23 and 46.	
J. Procedures for obtaining transportation for both emergency and non-emergency situations;	Deem for 2017			
K. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Deem for 2017			
L. Procedures for arranging EPSDT for persons under the age of 21 years;	Deem for 2017			
M. Procedures for obtaining access to Long Term Care	Deem for 2017			

Final Findings

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**
Services;				
N. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Deem for 2017			
O. A list of direct access services that may be accessed without the authorization of a PCP;	Deem for 2017			
P. Information about how to access care before a PCP is assigned or chosen;	Deem for 2017			
Q. A Member's right to obtain second opinion in or out of the Contractor's Provider network and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;	Deem for 2017			
R. Procedures for obtaining Covered Services from non-network providers;	Deem for 2017			
S. Procedures and timelines 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, the availability of assistance in the filing process, the right of the Member to a State Fair Hearing and that benefits will continue while under appeal if MCO decision is to reduce or terminate services;	New Requirement	Full	This requirement is addressed in the member handbook.	
T. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Deem for 2017			
U. Information on the availability of, and procedures for obtaining behavioral health/substance abuse	Deem for 2017			

Final Findings

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**
health services;				
V. Information on the availability of health education services;	Deem for 2017			
W. Any cost sharing imposed;	New Requirement	Full	This requirement is addressed in the member handbook.	
X. How to exercise an advance directive;	New Requirement	Full	This requirement is addressed in the member handbook.	
Y. Information deemed mandatory by the Department; and	Deem for 2017			
Z. The availability of care coordination, case management and disease management provided by the Contractor.	Deem for 2017			
31.3 Second Opinions				
At the Member's request, 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, or arrange for the Member to obtain a second opinion outside the network without cost to the Member. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Deem for 2017			
23.1 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 Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-	Deem for 2017		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	

Final Findings

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**
designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for all Contractor programs with the exception of behavioral health. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately.				
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).	Deem for 2017			
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.	Deem for 2017		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member written materials shall be provided and English, Spanish, and each prevalent non-English language. Oral interpretation shall be provided for all non-English languages. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively	Deem for 2017 New Requirement	Full	This requirement is addressed in the 4500.25 Interpreter and Translation Services Policy on page 3.	

Final Findings

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**
interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.				
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.	Deem for 2017			
The Contractor's Member Services function shall also be responsible for:	Deem for 2017			
A. Ensuring that Members are informed of their rights and responsibilities;	Deem for 2017			
B. Ensure each Member is free to exercise his or her rights without the Contractor or its Providers treating the Member adversely.	Full - This requirement is addressed on page 22 of the Member Handbook. Additionally, the requirement is stated verbatim on page 4 of the Member Rights and Responsibilities policy, second to last bullet on the page.			
C. Guaranteeing each Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.	Full - This requirement is stated verbatim on page 4 of the Member Services Functions policy, last bullet on the page.			
D. Monitoring the selection and assignment process of	Deem for 2017			

Final Findings

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**
PCPs;				
E. Identifying, investigating, and resolving Member Grievances about health care services;	Deem for 2017			
F. Assisting Members with filing formal Appeals regarding plan determinations;	Deem for 2017			
G. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Deem for 2017			
H. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Deem for 2017			
I. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Deem for 2017			
J. 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);	Deem for 2017			
K. Explaining or answering any questions regarding the	Deem for 2017			

Final Findings

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**
Member Handbook;				
L. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. 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;	Deem for 2017			
M. 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.	Deem for 2017			

Final Findings

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**
N. 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;	Deem for 2017			
O. 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;	Deem for 2017			
P. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases.	Deem for 2017			
Q. Facilitating access to behavioral health services and pharmaceutical services;	Deem for 2017			
R. 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;	Deem for 2017			
S. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility	Deem for 2017			

Final Findings

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**
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;				
T. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Deem for 2017			
U. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Deem for 2017			
V. Facilitating access to Member Health Education Programs;	Deem for 2017			
W. Assisting members in completing the Health Risk Assessment (HRA) 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	Deem for 2017			
X. 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.	Deem for 2017			
31.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall	Deem for 2017			

Final Findings

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**
not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.				
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid Covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.	Deem for 2017			
24.0 Member Selection of Primary Care Provider (PCP)				
24.1 Members Not Required to have a PCP				
Dual Eligible Members, Members who are presumptively eligible, adults for whom the state is appointed guardian, disabled children, and foster care children are not required to have a PCP.	Deem for 2017			
24.2 Member Choice of Primary Care Provider				
Members shall choose or have the Contractor select a	Deem for 2017			

Final Findings

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**
PCP for their medical home.				
The Contractor shall have two processes in place for Members to choose a PCP: A. A process for Members who have SSI coverage but are not Dual Eligible Members; and B. A process for other Members.	Deem for 2017			
24.6 Primary Care Provider (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.	Deem for 2017			
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.	Substantial - Page 10 of the Member Handbook states that members have the right to change their PCP "within the rules" (4th bullet). The same wording is used on page 4 of the Member Rights and Responsibilities policy (4500.35). However, the 10-day timeframe is not specified. There is no other documentation that was submitted that addresses this requirement. Recommendation for Aetna As we indicated last year, it is recommended that the MCO add the ten (10) day requirement specifically to the policy rather than just referring to "within the rules".	Full	This requirement is addressed in the 4500.12 Member Notice of Primary Care Practitioner (PCP) Termination Policy, which was updated to include the 10-day requirement and the PCP termination letter that is provided to members.	

Final Findings

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**
	MCO Response: DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. Policy 4500.12 Member notice of Primary Care Practitioner(PCP) termination was updated to include the 10 day requirement Final Review Determination No change in determination. Aetna updated the policy and it will be reviewed at the next compliance review.			
A Member shall have the right to change the PCP ninety (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 same Medicaid Region.	Full - Page 49 of the Provider Manual addresses this requirement in full in the first two paragraphs under "Procedure for members to change PCP".			
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or	Deem for 2017			

Final Findings

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**
her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.				
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship Member has not utilized a service within one year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or inability to meet the medical needs of the Member.	Deem for 2017 New Requirement	Full	This requirement is addressed in the A-KY 4500.86 Member Disenrollment Disruptive Member Transfer Policy.	
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.	Deem for 2017			
The initial PCP must serve until the new PCP begins serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The PCP shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.	Deem for 2017			
31.5 Referrals for Services not Covered by Contractor				

Final Findings

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**
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, 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 Members 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.	Deem for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Suggested Evidence

Documents

Policies/Procedures for:

- Member rights and responsibilities
- Member Handbook
- Choice of primary care provider
- 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

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 (MCO Report #11)

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Aetna Better Health of Kentucky

Final Findings

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**
23.3 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 its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Deem for 2017			
Creative methods should be used to reach Contractor's 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.	Deem for 2017			
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.	Deem for 2017			
23.4 Outreach to Homeless Persons	Deem for 2017			
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Deem for 2017			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Deem for 2017			

Final Findings

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 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.	Deem for 2017			
23.5 Member Information Materials				
All written materials provided to Members that are critical to obtaining services, including, at a minimum, marketing materials, new member information, provider directories, handbooks, denial and termination notices, and grievance and appeal information shall comply with 42 CFR 438.10(d) and 45 CFR 92 unless otherwise specifically addressed in this Contract. The information shall at a minimum:	Deem for 2017 New Requirement	Full	This requirement is addressed in the Member Materials Standard Policy 4500.20.	
A. Be geared toward persons who read at a sixth-grade level and use easily understood language and format;	Deem for 2017 New Requirement	Full	This requirement is addressed in the Member Materials Standard Policy 4500.20.	
B. Be published in at least a twelve (12) point font size, and available in large print in a font size no smaller than 18 point, except font size requirements shall not apply to Member Identification Cards;	New Requirement	Full	This requirement is addressed in the Member Materials Standard Policy 4500.20.	
C. Comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Deem for 2017			
D. Be available through auxiliary aids and services, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in the Member Materials Standard Policy 4500.20 and the member welcome kit.	
E. Be available in alternative formats, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in the Member Materials Standard Policy 4500.20 and the member welcome kit.	

Final Findings

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**
F. Be available in English, Spanish and each prevalent non-English language	New Requirement	Full	This requirement is addressed in the member welcome kit.	
G. Be provided through oral interpretation services for any language;	New Requirement	Full	This requirement is addressed in the Interpreter and Translation Services Policy 4500.25 on page 3.	
H. Must include taglines in the top 15 non-English languages as released by the U.S. Department of Health and Human Services Office of Civil Rights, as well as large print, explaining the availability of written translation or oral interpretation and the toll-free telephone number of the Contractor's entity providing those services and how to request services.	New Requirement	Full	This requirement is addressed in the Interpreter and Translation Services Policy 4500.25 on page 3.	
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.	Deem for 2017			
29.14 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, disabilities and regardless of gender, sexual orientation or gender identity. 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	Deem for 2017 New Requirement	Full	This requirement is addressed in the Member Materials Standard Policy 4500.20.	

Final Findings

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**
interpersonal communication styles which respect Member's cultural background.				
The Contractor shall communicate such policies to Subcontractors.	Deem for 2017			

Final Findings

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	9	0	0	0
Total Points	27	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

Policies/procedures for Member informational materials
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

Final Findings

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**
32.1 Pharmacy General Requirements				
The Contractor shall administer pharmacy benefits in accordance with this section, other requirements specified in this contract, and in accordance with all applicable State and Federal laws and regulations. In accordance with the Contractor's Formulary and/or Preferred Drug List, the Contractor shall provide coverage for all medically necessary legend and non-legend drugs once a drug becomes FDA approved and eligible for manufacturer federal rebates in accordance with Section 1927 of the Social Security Act, and ensure the availability of quality pharmacy services for all enrollees.. 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 (ProDUR) and edits;	Deem for 2017			
B. An accounts receivable (A/R) process that includes records for the Department to systematically track adjustments, recoupments, manual payments, and other required identifying A/R and claim information;	Deem for 2017			
C. Retrospective drug utilization review (RetroDUR) services;	Deem for 2017			
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, a PA escalation process and procedure, an appeals process, and a Pharmacy	Substantial - Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports. Q4 2015 results were not reviewed	Substantial	This requirement is partially addressed in A-KY 7600.10 (Formulary Policy), A-KY 7600.12 (Non-Formulary Policy) & A-KY 7600.30 (Pharmacy and	Agree- A-KY 3100.70 Member Appeals Policy (bottom of page 8) and 3100.70F Member Pharmacy Appeal Desktop were updated to include prior authorization

Final Findings

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**
and Therapeutics Committee (P&T);	since they were not available at the time of the compliance review). These requirements are addressed in policy A-KY 7600.07 Pharmacy Prior Authorization-effective 2/1/2016, which addresses the prior authorization process, (PA) and the notice of action (NOA), page 2, as well as provider ability to request a peer to peer review for denials. Policy A-KY 7600.12 Non Formulary Management indicates that providers and members will be instructed on how to file an expedited appeal upon notice of denial. Policy 7600.10 and KY Formulary Management outlines processes for incorporating formulary changes into the program. The procedures document Prior Authorization Process Updated 2_1_16 includes a schematic of authorization and appeals procedures; appeals originate with the appeals coordinator in this schematic. Quarterly report #39 included detail by region and behavioral health drug category of prior authorization denials, and pharmacy (behavioral heath and non behavioral health) prior authorization and denials are present in quarterly report #59 and compared to other categories of prior authorization requests. The Pharmacy and Therapeutics (P & T) Committee charter document describes the role,		Therapeutics Policy). However no documentation was provided that describes the prior authorization escalation policy. **<u>Recommendation MCO</u>** The MCO should include a pharmacy prior authorization escalation process and procedure in their policy. This was also a recommendation in the prior compliance review.	escalation process from pharmacy denial through appeal process.  3100.70F Member Pharmacy Appeal Pr Policy A-KY 7600.07 Pharmacy Prior Authorization was also updated to include a cross-reference to the updated 3100.70 Member Appeal Policy- see page 7.

Final Findings

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**
	composition and meeting frequency of the P&T committee. P&T reports are included in the Quality Management Oversight Committee minutes, and P&T minutes were also provided for review. Although the document Prior Authorization Process Updated 2_1_16 includes a schematic of appeals procedures, a prior authorization escalation process from pharmacy denial through appeal process is not included in policy. The Policy and Procedure documents provided do not demonstrate how pharmacy prior authorization denials are linked to the appeals process. Onsite staff provided examples of pharmacy denial letters onsite, which include appeal information in the Notice of Action. The Member Handbook indicates that if pharmacy authorization is denied, the member will be notified how to start the appeal process. **Recommendation for Aetna** Aetna should include a pharmacy prior authorization escalation process and procedure in policy. MCO Response: Policy A-KY 7600.07 Pharmacy Prior Authorization was updated to include a reference to the Member Appeal Policy 3100.70 which outlines both the member appeal process and timelines.			

Final Findings

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**
	DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. **Final Review Determination** No change to determination. A reference to the contract language is not appropriate for this recommendation as it requires a specific procedure to be put in place.			
E. Pharmacy Provider relations and education, and call center services (member and provider), in addition to provider services specified elsewhere;	Deem for 2017			
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;	Deem for 2017			
G. Claims payment services;	Deem for 2017			
H. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;	Deem for 2017			
I. Assisting the Department by cooperating and providing support during internal and external audits, including CMS certification or reviews, or transitions or upgrades of any MMIS/MEMS systems; and	Full - This requirement is addressed in the Quality Management Oversight Committee (QMOC) minutes on 5/16/2016, page 12 and Pharmacy Therapeutics Committee Policy (revised 2/1/2016), and page 3 with regards to internal audits.			

Final Findings

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**
	State regulators are identified as external interdependent agents with the MCO in policy A-KY 7600.20 Pharmacy Benefits Management. Onsite staff indicated that they have assisted with the file layout for pharmacy reporting-migration to NCPDP 2.02.0 and responding to ad hoc requests. MCO Response: Policy KY-A7600.20 Pharmacy Benefits Management was updated to include a statement outlining Aetna Better Health of Kentucky's cooperation in providing documentation, reports, and support to the Department during internal and external audits. DMS previously advised the MCO that if our policies referenced the section number from the contract we would not be required to specifically site the language in the policy. Please advise. **Final Review Determination** This determination was changed to Full after discussion with DMS that allows contract sections be addressed in the MCOs policies.			

Final Findings

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**
J. Pursuant to Section 1903(i) of the Social Security Act, all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three (3) of the following: 1. Copying of a completed or blank prescription form; 2. Erasure or modification of information written on the prescription pad by the prescriber; AND 3. Use of counterfeit prescription forms. This requirement does not pertain to prescriptions received by fax, telephone, or electronically.	New Requirement	Full	This requirement is addressed in the Suspected Fraudulent or Altered Prescriptions policy on page 6.	
32.5 Formulary and/or Preferred Drug List				
The Contractor shall maintain a drug formulary and/or preferred drug list (PDL) which follows the general and minimum requirements herein:	Deem for 2017			
A. The formulary and/or PDLshall: 1) Be made available to Providers and Members, including the tier for each medication and other information as necessary; 2) Only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1993; 3) Be developed by a P&T that shall	New Requirement	Substantial .	This requirement is partially addressed below by subparts: 1) This requirement is addressed in A-KY 7600.10, the Formulary Policy. 2) This requirement is addressed in A-KY 7600.10, the Formulary Policy. 3) No documentation was provided that meets this requirement. 4) This requirement is addressed in policy 7600.30 Pharmacy and	Agree- KY 7600.30 P&T policy updated to include #3 requirement - see page 6. KY 7600.12 Non-Formulary Management policy updated to include #5 requirement is met by the Policy-see page 3.

Final Findings

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**
represent the enrollees including those with special needs; 4) For each therapeutic drug class, the selection of drugs included shall be sufficient to ensure the availability of covered drugs with the least need for prior authorization; and 5) Not be used for the sole purpose to deny coverage of any Medicaid covered outpatient drug. 6) Be reviewed on a rolling basis so that all represented classes are reviewed within at least a three (3) year period.			Therapeutics Committee. 5) No documentation was provided that meets this requirement. 6) This requirement is addressed in A-KY 7600.10, the Formulary Policy. **Recommendation for MCO** The MCO should include the contract requirements for subparts #3 and #5 in a policy.	
B. If the formulary and/or PDL prefers generic equivalents, Contractor shall provide a brand name exception process for prescribers to use when medically necessary.	New Requirement	Full	This requirement is addressed in 7600.11, Generic Substitution Policy.	
C. Publication of formulary and/or PDL: 1) Contractor shall publish and make available via hard copy upon request, online/webpage or web portal, or by other relevant means of communication its current formulary and/or PDL to all Providers and Members. 2) Formulary and/or PDL drug lists shall be made available on Contractor's web site in a machine readable file and format as specified in 42	New Requirement	Full	This requirement is addressed in A-KY 7600.10, Formulary Policy.	

Final Findings

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**
CFRC.F.R. section 438.10. 3) The formulary and/or PDL shall be updated by the Contractor throughout the year and shall reflect changes such as, status of a drug, adds or deletes. Updates to the formulary and/or PDL shall be distributed in the formats herein mentioned no later than the effective date of changes.				
32.4 Pharmacy and Therapeutics Committee				
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T) in accordance with KAR Title 907. The P&T shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the PDL or drug formulary. The P&T shall be considered an advisory committee to a public body thereby making it subject to Kentucky's Open Meetings Law. Prior to each new calendar year, the Contractor shall give notice to the Department of the time, date and location of the P&T meetings.	Deem for 2017			
32.7 Pharmacy Claims Payment Administration				
The Contractor shall: Process, adjudicate, and pay Kentucky Medicaid pharmacy claims, including voids and full or partial adjustments, via an online, real-time POS system by:	Full-2016			

Final Findings

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**
32.6 Pharmacy Drug Rebate Administration				
The Affordable Care Act requires 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 on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. The Department or its designated contractor will provide this claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	Deem for 2017			

Final Findings

Pharmacy Benefits

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.60**		

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

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

Final Findings
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
- Medicaid prescriptions

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
Process for monitoring and managing the pharmacy program

Reports

Evidence of reporting and analysis of the pharmacy program to ensure compliance with Federal and State requirements
Monthly Formulary Management (MCO Report #39)
Prior Authorizations (MCO Report #59)