IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

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 Passport's 2016 Quality Improvement Program Description page 6.			
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Full - This requirement is addressed in Passport's 2016 Quality Improvement Program Description page 7.			
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - This requirement is addressed in Passport's 2016 Quality Improvement Program Description page 6.			
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 addressed in Passport's 2016 Quality Improvement Program Description page 11.			
The QAPI program shall be developed in	Full - This requirement is addressed in the agenda and minutes			

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collaboration with input from Members.	provided by Passport Quality and Member Access Committee which met four times on 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016 (as seen in the provided signed minutes).			
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - This requirement is addressed in the agenda and minutes provided by Passport Quality and Member Access Committee which met four times on 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016 (as seen in the provided signed minutes) and by the Quality Medical Management Committee in the agenda and minutes on 2/9/2016, 5/10/2016, 6/14/2016, 7/12/2016, 8/16/2016 and 9/20/2016.			
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 - This requirement is addressed in the certificate document that provides Passport accreditation status that expires on 9/4/2017. The MCO obtained NCQA commendable status for the time period of 9/4/2014 to 9/4/2017.			
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS) Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures,	Full - This requirement is addressed in the certificate document that provides Passport accreditation status that expires on 9/4/2017. NCQA commendable status for the time period of 9/4/2014 to 9/4/2017.			

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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 - This requirement is addressed in the 2016 Quality Improvement Program description, pages 9-11.			
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 Quality Improvement Program description, pages 9-11 and the 2015 Quality Improvement Evaluation. Behavioral Health services will be delegated by Beacon Health Strategies (BHS), a subcontractor, as noted on page 8.			
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 9-11.			
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	SNP.QI.101.E.KY, PHP QI 2017 and 2017 EPSDT Program Evaluation-Final provide a description of this mechanism and the QMMC 2017 Q4 QI Report includes significant findings from the work plan.	
19.2 Annual QAPI Review				

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The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes 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	Full - Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results) This requirement is addressed in the 2016 Quality Improvement Program description on page 11 and in the following statement: "As a recommendation of the EQRO, quantifiable goals, a timeline for implementation of activities and achievement of goals, and an annual 'Executive Summary' of the Work Plan highlighting key milestones as well as the dates that the milestones were achieved is completed annually are incorporated into the QI Work Plan. The final document is presented to the Quality Medical Management Committee, the Partnership Council, and the UHC Board for review and approval."		Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results).	

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behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.				
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 - This requirement is addressed in the 2016 Quality Improvement Program description, pages 6-11 and the 2015 Quality Improvement Work Plan, pages 97-106, and 2015 QI Evaluation, pages 1-2.			
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 - This requirement is addressed in the 2016 Quality Improvement Program description, pages 6-11 and the 2015 Quality Improvement Work Plan, pages 97-106, and 2015 QI Evaluation, pages 1-2.			
22.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and	Full - This requirement is addressed in: the 2016 Quality Improvement Program description, page 11, and the 2016			

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
evaluations in accordance with established protocols previously described.	Quality Improvement Work Plan, pages 97-106 and the 2015 Quality Improvement Evaluation, page 74.			
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, page 11, and the 2016 Quality Improvement Work Plan, page 104 and the 2015 Quality Improvement Evaluation, pages 8, 12, and 50.			
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 - This requirement is addressed in the 2016 Quality Improvement Program description, pages 5-6 and the 2015 Quality Improvement Evaluation.			
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - This requirement is addressed in the 2016 Quality Improvement Evaluation, page 1 and Quality Improvement Work Plan, pages 102-106.			

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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 - This requirement is addressed in the 2016 Quality Improvement Program description and QMMC 7/19/2016 minutes.			
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification; An extension to submit may be extended in accordance with Section 40.4.D;	Full - This requirement is addressed in the 2016 Quality Improvement Work Plan.			
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 2016 Quality Improvement Program description, the 2016 Quality Improvement Work Plan, pages 101-106 and the 2015 Quality Improvement Evaluation, pages 60-75.			
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 was given an opportunity to provide responses to the preliminary Compliance Review findings and the responses were considered by DMS and IPRO, the EQRO. PHP did not disagree with any other findings of the EQRO.			

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19.3 QAPI Plan			Includes review of MCO report #17 QAPI Work Plan, MCO Report #84 QAPI Program Description, MCO 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 - Includes review of MCO report #17 QAPI Work Plan, MCO Report #84 QAPI Program Description, MCO Report #21 MCO Committee Activity and MCO Report #85 QI Plan and Evaluation (see Quarterly Desk Audit results)			
outlines the scope of activities and	Full - This requirement is addressed in the 2016 Quality Improvement Work Plan in the final 3rd quarter report (#17).			
the goals,	Full - This requirement is addressed in the 2016 Quality Improvement Work Plan 3rd quarter report (#17).			
objectives, and	Full - This requirement is addressed in the 2016 Quality Improvement Work Plan 3rd quarter report (#17).			
timelines for the QAPI program.	Full - This requirement is addressed in the 2016 Quality Improvement Work Plan 3rd quarter report (#17).			
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 - This requirement is addressed in the 2016 Quality Improvement Work Plan 3rd quarter report (#17) and the 2015 Quality Improvement Evaluation pages 7-9.			
The Contractor is accountable to the	Full - This requirement is addressed in: The 2016 Quality			

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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;	Improvement Work Plan 3rd quarter report (#17) and the 2015 Quality Improvement Evaluation pages 3-11 and the QI Work Plan and meeting minutes (8/8/2016) and QMMC minutes (8/16/2016).			
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - This requirement is addressed in the 2016 Quality Improvement Program description, page 4 and the QI Work Plan and meeting minutes (8/8/2016) and QMMC minutes (8/16/2016).			
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 - This requirement is addressed in the 2016 Quality Improvement Program description page 6.			
review on an annual basis of the QAPI program; and	Full - This requirement is addressed in the 2016 Quality Improvement Program description, page 3-11 and updated meeting minutes.			
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, page 7 and the 2015 Quality Improvement Evaluation, page 1.			
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 Quality Improvement Program description, pages 1-2, the 2016 Quality Improvement Work Plan pages 101-107, and the 2016 Quality Medical Management Committee description and minutes are noted.			

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The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 2 -9 and the Quality Medical Management Committee description (Consumer advocate and Medical Ethicist seen on representative class list noted on description above).			
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 2016 Quality Improvement Program description, pages8-11 and the Quality Medical Management Committee description and minutes.			
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, the 2016 Quality Improvement Work Plan, and the 2015 Quality Improvement Evaluation.			

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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 - This requirement is addressed in the 2016 Quality Improvement Program description, pages 4-7, QMMC meeting minutes updated the 2016 Quality Improvement Work Plan with updates and the 2015 Quality Improvement Evaluation.			
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 care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 9-11 the 2016 Quality Improvement Work Plan and the 2016 QMMC updated minutes.			
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	Full - This requirement is addressed in the 2016 Quality Improvement Work Plan, the quarterly reports and updates.			

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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 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.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 3-7, the 2016 Quality Improvement Work Plan, pages 101-107 and the 2015 Quality Improvement Evaluation.			
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 3-7, the 2016 Quality Improvement Work Plan, pages 101-107 and the 2015 Quality Improvement Evaluation.			

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Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 3-7, the 2016 Quality Improvement Work Plan, pages 101-107 and the 2015 Quality Improvement Evaluation.			
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Full - This requirement is addressed in the 2016 Quality Improvement Program description, pages 3-7, the 2016 Quality Improvement Work Plan, pages 101-107 and the 2015 Quality Improvement Evaluation.			
The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Full - This requirement is addressed in the 2016 Quality Improvement Program Description pages 1-10 and the 2016 Quality Improvement Work Plan, pages 101-107. QMMC minutes were updated.			
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 2016 Quality Improvement Program Description, pages 4-9.			
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 Quality Improvement Program Description page11 and the 2016 Quality Improvement Work Plan, pages 101-107.			
The Contractor shall develop or adopt	Full - This requirement is addressed in the 2016 Quality			

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practice guidelines that are disseminated to Providers and to Members and Potential Enrollees upon request.	Improvement Program Description pages 4-7 and the 2016 Quality Improvement Work Plan, pages 101-107.			
Mental Health and Substance Use practice guidelines shall also be submitted to the Department and DBHDID.	Full - This requirement is addressed in the: 2016 Behavioral Health Provider Contracting and Enrollment Policy on pages 1-3.			
The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals;	Full - This requirement is addressed in the 2016 Quality Improvement Program Description pages 6-7 and Clinical Practice Guidelines are individually noted for each topic/illness.			
consider the needs of Members;	Full - This requirement is addressed in the 2016 Quality Improvement Program Description pages 6-7 and Clinical Practice Guidelines are individually noted for each topic/illness.			
developed or adopted in consultation with contracting health professionals, and	Full - This requirement is addressed in the 2016 Quality Improvement Program Description pages 7-8.			
reviewed and updated periodically.	Full - This requirement is addressed in the 2016 Clinical Practice Guidelines Activity summary, tracking and updates.			
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 UM and Clinical Programs Description, pages 3-5.			
20.1 Kentucky Outcomes Measures and HEDIS Measures				

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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 performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Full - This requirement is addressed in the 2016 Quality Improvement Program Description pages 6-7.			
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 followed the HEDIS rotation schedule.			
The Contractor in collaboration with the	Full - This requirement is addressed in the 2016 Quality			

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Department and the EQRO shall develop and initiate a performance measure specific to Individual Members with Special Health Care Needs (ISHCN).	Improvement Program Description pages 8-9 and 2015 Quality Improvement Program (Population for Special Needs).			
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 - This is addressed in the trending of results reported in document Historical HEDIS and QC Rates Results. Results are shown in both spreadsheet and graph format for each measure. Passport and the other MCOs also participated in the Incentive Plan that is monitored by DMS.			
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 - This requirement is addressed in the Healthy Kentuckians Outcomes Measures Report. Report "Healthy Kentuckians Outcomes Measures Report" contains RY 2016 results which contain goals for each measure.			
20.3 Reporting HEDIS Performance Measures			Includes review of MCO Report #96 Audited HEDIS Reports (see Quarterly Desk Audit results).	

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The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31st.	Full - This requirement is addressed in the Healthy Kentuckians Outcomes Measures Report. This requirement is addressed in 2016 HEDIS Final Audit Report. Passport provided the HEDIS Final Audit Report, prepared by their NCQA-Licensed HEDIS Compliance Organization. All measures within the scope of the audit were determined to be reportable.			
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 Healthy Kentuckians Outcomes Measures Report. Trending of results is reported in document Historical HEDIS and QC Rates Results. Results are shown in both spreadsheet and graph format for each measure.			
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 Healthy Kentuckians Outcomes Measures Report			

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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 specific subset of measures for performance evaluation. The performance measure set is reviewed annually by DMS and IPRO.	Not Applicable	DMS did not provide the MCO with a subset of targeted performance measures.	
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 specific subset of measures for performance evaluation. The performance measure set is reviewed annually by DMS and IPRO.	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 measurement requirement.	New Requirement	Not Applicable	On site, the MCO indicated there were no measures identified by DMS.	

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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 - This requirement is addressed in: Passport received "Commendable" accreditation status effective 9/4/2014 through 9/30/2017. See a copy of the certification certificate in document "2014 Accreditation Results Certificate with Expiration dates."			
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 - Passport is NCQA accredited with "Commendable" status through 9/2017.			
20.5 Performance Improvement Projects (PIPs)	Includes review of MCO Reports: #19 PIPs #90 PIP Proposal		Includes review of MCO Reports: #19 PIPs, #90 PIP Proposal, and #92 PIP Measurement (see Quarterly Desk	

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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**
	#92 PIP Measurement (see Quarterly Desk Audit results)		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 - Passport submitted PIPs during the 2016 year, including proposals, baseline reports as directed by DMS annually.			
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider	Full - Passport submitted PIPs during the 2016 year, including proposals, baseline reports as directed by DMS annually.			

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**
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, 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	Full - This requirement is addressed in the Quality Medical Management Committee description with the Health Department representative as a member of the representative class. The 2016 QI Work Plan (report #17) on 10/26/2016 discusses community engagement through meetings and organization as			

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**
health agencies is an essential element for the achievement of public health objectives.	noted on page 89.			
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 establishment of relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection.	Full - Passport fully participates in and contributes to collaborative quality improvement efforts with DMS, the EQRO, government and community organizations as evidenced in the 2016 QI Work Plan, the 2015 Quality Improvement Evaluation and cooperation with EQRO activities.			
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	Full - Passport Submitted PIPs during the 2016 year, including proposals, baseline reports as directed by DMS annually.			

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**
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, 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 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 - Passport Submitted PIPs during the 2016 year, to IPRO including proposals, baseline, interim and final reports as directed by DMS annually.			
A. Topic and its importance to enrolled members;	Full - Passport Submitted PIPs during the 2016 year, to IPRO including proposals, baseline, interim and final reports as directed by DMS annually.			
B. Methodology for topic selection;	Full - Passport Submitted PIPs during the 2016 year, to IPRO including proposals, baseline, interim and final reports as directed by DMS annually.			
C. Goals;	Full - Passport Submitted PIPs during the 2016 year, to IPRO including proposals, baseline, interim and final reports as			

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**
	directed by DMS annually.			
D. Data sources/collection;	Full - Passport Submitted PIPs during the 2016 year, to IPRO including proposals, baseline, interim and final reports as directed by DMS annually.			
E. Intervention(s) – not required for projects to establish baseline; and	Full - Passport Health Plan acted on recommendations by IPRO to improve the intervention strategies in a robust and meaningful manner. They targeted specific interventions to implement for each PIP (as described in each PIP report)			
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 - Passport Submitted PIPs during the 2016 year, including proposals, baseline reports and interim reports as directed by DMS annually Annual HEDIS performance indicators followed.			
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Full - Passport submitted the final PIP Report Psychotropic Drug Intervention Program (PDIP) for Selective Serotonin Reuptake Inhibitor (SSRIs) and Serotonin/Norepinephrine Reuptake Inhibitor (SNRIs). All Plan associates, including temporary employees, receive a copy of the code of conduct and the corporate compliance confidentiality policy and must sign a statement that the policy was received and understood.			
B. Did Members participate in the performance improvement project;	Full - Members participated by taking an active role in their treatment plan.			
C. Did the performance improvement	Full - The MCO stated in the PIP that it is known that the higher			

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**
project include cost/benefit analysis or other consideration of financial impact;	cost of psychotropic medications, prevalence of non-specialist prescribers and the inappropriate prescription and/or usage of psychotropic drugs can negatively impact cost/benefit ratio.			
D. How financial impact might determine sustainability of improvement achieved;	New Requirement	Full	Final PIP for Safe and Judicious use of Antipsychotics addresses financial impact and sustainability separately, but not specifically how financial impact might determine sustainability; however, this PIP was initiated prior to this new requirement. On site, the MCO discussed how they 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.	
E. Were the results and conclusions made available to members, providers and any other interested bodies;	Full - According to the PIP, results of the project will be shared with the BH Advisory Group, PCP Workgroup, and QMMC. Passport will also plan to do a provider electronic newsletter communication summarizing results and reinforce importance of attending to the information. For members a results summary article will be submitted for publication to the plan quarterly newsletter.			

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 results have been shared with providers at the Behavioral Advisory Committee meeting 9/22/16. It is scheduled on the QMMC January agenda and results are scheduled to be shared with members at the February QMAC meeting. It was requested by the committee administrator to reduce the technicality of the report and thus it is scheduled in the February meeting. Sharing with the PCP workgroup is scheduled at the next meeting, newsletters are pending.			
F. Is there an executive summary;	Full - Passport included and abstract and next steps in the PIP.			
G. How could findings be reported to a broad audience of relevant stakeholders or the general public; and	New Requirement	Full	Minutes from the Quality and Member Access Committee (QMAC), 12/11/17, document review of all PIPs to a group that included member and a broadly representative group of community representatives. On site, the MCO elaborated on how PIP findings are shared with a broad audience of relevant stakeholders, including member representatives.	
H. Do illustrations – graphs, figures, tables – convey information clearly?	Full - The PIP contained information clearly including figures, tables and graphs.			
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	Full - HEDIS and CAHPS measures were used and appropriately reported.			

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**
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				
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	Full - PIP reports compared baseline, interim and final rates to evaluate whether improvements were sustained.			
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 - Deadline for PIP project addressed in a timely fashion.			
B. 1st Remeasurement – no more than one calendar year after baseline measurement and no later than	Full - Deadline for PIP project addressed in a timely fashion.			

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**
September 1 of the Contract year following baseline measurement.				
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 - The MCO met submission requirements for the Conclusion section.			
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)		Includes review of MCO Report #21 MCO Committee Activity and MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	
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 - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
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	Full - This requirement is addressed in the minutes. The 2017 QMAC Charter-updated 8/8/16 and Partnership Council TBD and The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			

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**
Member participation. Responsibilities of the Committee shall include:				
A. Providing review and comment on quality and access standards;	Full - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
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 - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
C. Providing review and comment on Member Handbooks;	Full - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
D. Reviewing Member education materials prepared by the Contractor;	Full - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
E. Recommending community outreach activities; and	Full - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were			

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**
	2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - This requirement is addressed in the minutes. The Quality and Member Access Committee (QMAC) met four times in 2016 in accordance with its Charter. The meeting dates were 2/8/2016, 6/13/2016, 8/8/2016 and 10/10/2016.			
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)		Includes review of MCO Report #94 Member Surveys and 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 provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full - This requirement is addressed in the Adult 2016.pdf and Child 2016.pdf with the survey instruments noted in report #95. Comment for 2016 compliance review findings: Under the Child CAHPS the 2015 Overall Rating of Specialists should have been 87%, not 97%.			
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - This requirement is addressed in the Adult 2016.pdf and Child 2016.pdf with the survey instruments noted in report #95.			
Annually, the Contractor shall assess the need for conducting special surveys to	Full - This requirement is addressed in 2016 Quality Management Activity Committee Charter-updated/revised on (QMAC) 8/8/16			

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**
support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.	and Partnership Council TBD.			
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 Practitioner Satisfaction Survey Results (report #95).			
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used 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: Adult 2016.pdf and Child 2016.pdf with the survey instruments noted in report #95.			
All survey results must be reported to the Department, and upon request,	Full - This requirement is addressed in the: Adult 2016.pdf and Child 2016.pdf with the survey instruments noted in report #95.			

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**
disclosed to Members.				
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 was addressed in the 2016 Quality Improvement Program description, page 11, and the 2016 Quality Improvement Work Plan, (3rd Quarter Report).		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: Passport Health Plan

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	3	0	0	0
Total Points	9	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: Passport Health Plan

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.	Full - This is addressed in the MCO's policy and procedure MS 16.0 Grievance Intake Process policy that details the steps the MCO takes to facilitate members' grievance reporting. CP5.20 Member Appeals policy purpose is to ensure a member's right of an appeal request when he or she is dissatisfied with a resolution to a grievance.			
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:	Full - This is addressed in policy and procedure MS 16.0 and CP 5.20 and all policies were approved by DMS during the readiness review in November 2013.			
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);	Full - This requirement is addressed in CP 5.20 Member Appeals on page 3. Communicated to members in the Member Handbook and in the acknowledgement template letter. New Requirement	Full	This requirement is addressed in the CP 5.20 Member Appeals Policy, as well as in the member handbook at pages 33–34.	

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**
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 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);	Full - This requirement is address in policy in CP 5.20 Member Appeals on page 6 New Requirement	Full	This requirement is addressed in the CP 5.20 Member Appeals Policy on page 9.	
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;	Full - This requirement is address in policy in CP 5.20 Member Appeals on page 6.			
D. Consider the Member, the Member's representative, or the legal representative of the Member's estate as parties to the appeal;	Full - This requirement is address in policy in CP 5.20 Member Appeals on page 3.			
E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	Full - This requirement is addressed in policy CP 05.20 Member appeals on page 5.			
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 - The UM Department keeps a separate policy from the Grievance Department. Medical records are kept in a secure environment for 10 years.			

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;	Full - This requirement is address in policy in CP 5.20 Member Appeals on page 7 and policy MS.016 E.KY Grievance Intake Process on page 3. New Requirements	Substantial	Includes member grievance – random, member grievance – quality, and member appeal file review results. This requirement is addressed in the CP 5.20 Member Appeals Policy. **Member Grievance – Random File Review Results** Ten (10) of 10 files were resolved within the 30-day timeframe; 1 file requested the need for an extension and this request was timely and met all requirements. **Member Grievance – Quality File Review Results** Eight (8) of 10 files were resolved within the 30-day timeframe. All 7 files that contained MCO requests for an extension met all requirements and the member was notified in a timely manner. The other 3 files did not have an extension and were designated not applicable for the extension requirement. **Member Appeal File Review Results** Ten (10) of 10 files were resolved within the 30-day timeframe. Ten (10) of 10 files were designated not applicable, because there was no extension of the timeframe. **Recommendation for MCO** The MCO should resolve all member	**Passport's Response** Passport Health Plan acknowledges receipt of IPRO's recommendation.

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**
			grievances within the 30-day timeframe.	
H. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full - Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results This is addressed in policy MS.024.E.KY Member Appeal-Member Service Final on page 2. Member Grievance Random File Review 10 of 10 NA Member Grievance Quality File Review 10 of 10 NA Member Appeal File Review		Includes member grievance – random, member grievance – quality, and 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**
	10 of 10 compliant			
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;	Full - Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results This requirement is address in policy in CP 5.20 Member Appeals on page 6. Member Grievance Random File Review 10 of 10 NA Member Grievance Quality File Review 6 of 6 compliant, 4 NA Member Appeal File Review 10 of 10 compliant		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;	Full - This is addressed in the Member Handbook on page 38.			
K. Provide assistance to Members in filing a grievance if requested or needed including, but not limited to, auxiliary	Full - This is addressed in the Member Handbook on pages 37 and 40.			

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**
aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;				
L. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Full - This is addressed in the Member Handbook on page 58. This is also addressed in the member appeals policy on page 8 and the Grievance Intake Process on page 2.			
M. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Full - This is address in the Member Handbook on page 40.			
N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Full - Includes Member Grievance Random and Member Grievance Quality file review results Member Grievance Random File Review 10 of 10 compliant Member Grievance Quality File Review 10 of 10 compliant		Includes member grievance – random, member grievance – quality, and member appeal file review results.	
O. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	Full - The following documents meet the requirement: MS 24.0 Member Appeals – Member Services, CP 5.20 Member Appeals and 2014 Utilization Management and Clinical Programs Description section XII Appeals pages 28-31.			

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**
P. Provide for continuation of services, if appropriate, while the appeal is pending;	Full - This requirement is met in CP 5.20 Member Appeals page 2.			
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;	Full - This requirement is met in CP 5.20 Member Appeals page 2.			
R. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal and must be confirmed in writing;	New Requirement	Full	This requirement is addressed in the CP 5.20 Member Appeals Policy on page 3.	
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 met in CP 5.20 Member Appeals page 2.	Full	This requirement is addressed in the CP 5.20 Member Appeals Policy on page 6.	
T. Inform the Member of the limited time to present evidence and allegations of fact or law in the case of an expedited appeal;	Full - This is addressed in the member hand book on page 39 and in the Notice of Action (NOA) template.			
U. Acknowledge receipt of each grievance and appeal;	New Requirement	Full	This requirement is addressed in the acknowledgment letter received by the members.	
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;;	Full - This is addressed in the member handbook on page 38. New Requirement	Full	This requirement is addressed in the member handbook on pages 44–45.	
W. Provide for the right to request a hearing under KRS Chapter 13B;	Full - This is addressed in the member handbook on page 39.			

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	Full - This is addressed in the member handbook on page 38.			
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.	Full - This is addressed In the Notice of Action.			
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, or D.	Full - This requirement is addressed in CP 5.20 on page 4.			
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	Full - This is partially addressed in Policy PHP 20 – Record Retention Policy. It is further addressed in the Medical Records Storage Desk Top Procedure.			

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 and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information. Documentation regarding the grievance shall be made available to the Member, if requested.				
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)	Full - Includes Member Random and Member Quality Grievance file review results This requirement is addressed in policy and procedure MS 16.0 Grievance Intake Process page 4. This information is communicated to members in the Member Handbook page 38. Member Grievance Random File Review 5 of 5 compliant, 5 NA Member Grievance Quality File Review 8 of 8 compliant, 2 NA		Includes member grievance – random and member grievance – quality file review results.	.
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.	Full - Includes Member Random and Member Quality Grievance file review results Addressed in CP 5.20. Communicated to members in the Member Handbook and DMS approved template letter.		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**
KAR 17:010 Section 4 (2) (b)	Member Grievance Random File Review 9 of 9 compliant for the 30 day timeliness, 1 of 1 an extension granted and 14 day extension timeliness was compliant. 10 of 10 compliant for resolution letter Member Grievance Quality File Review 7 of 7 files were compliant for the 30 day timeliness criteria. 3 files had and extensions granted and were timely for the 14 day timeliness criteria. 10 of 10 compliant for resolution letter			
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe. 42 CFR 438.408 (c)	Full - Includes Member Random and Member Quality Grievance file review results This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook and also in letter template. Member Grievance Random File Review 1 of 1 compliant		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**
	Member Grievance Quality File Review 3 of 3 compliant			
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 Member Appeal file review results This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and in the acknowledgement template letter. Member Appeal File Review 10 of 10 compliant		Includes member appeal file review results.	
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)	Full - Includes Member Appeal file review results This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and template letters Member Appeal File Review		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**
	10 of 10 compliant			
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)	Full - Includes Member Appeal file review results This is addressed in the member handbook on page 38 and policy CP 5.20 page 7. Member Appeal File Review 10 of 10 NA		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)	Full - Includes Member Appeal file review results This requirement is addressed in CP 5.20. Communicated to members in the Member Handbook on page 38 and in the acknowledgement template letter. Member Appeal File Review 10 of 10 compliant		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, including medical or clinical records (subject to HIPAA	Full - Includes Member Appeal file review results This requirement is addressed in CP		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**
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)	5.20. Communicated to members in the Member Handbook page 38 and in the acknowledgement template letter. Member Appeal File Review 10 of 10 compliant			
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)	Full - Includes Member Appeal file review results This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook and template letters. Member Appeal File Review 10 of 10 were compliant		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.	Substantial Includes Member Appeal file review results This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook on page 39 and template letters.	Full	Includes member appeal file review results. This requirement is addressed in the CP 5.20 Member Appeals Policy and is communicated to the member in the member handbook. **Member Appeal File Review Results** Five (5) of 10 files contained the state fair hearing language. The remaining 5 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**
42 CFR 438.408 (e) (2)	Member Appeal File Review 5 of 5 had the right to request a state fair hearing, 5 were NA 5 of 5 had the right to request benefits, 5 were NA 0 of 5 contained in the resolution letter the reference that a member may be held liable for the cost. Recommendation for Passport The resolution letter should provide the language the language that a member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. <u>Passport's Response</u> Passport Health Plan has acted upon IPRO's recommendation by adding to the Resolution Letter the language that a member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action.		were not applicable because the decisions were overturned and the file did not warrant state fair hearing notification. Five (5) of 10 files contained the right to request receipt of benefits. The remaining 5 files were not applicable because the decisions were overturned and the file did not warrant the member being notified about their rights to request benefits. Five (5) of 10 files informed the member that they may be held liable for the cost of continuing benefits. The remaining 5 files were not applicable because the decisions were overturned and the file did not warrant the member notified about continuing benefits.	
Expedited Appeals File Review				
The Contractor shall resolve the appeal within three	Full - Includes review results for		Includes file review results for member	.

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**
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)	Member Appeals if expedited This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook on page 39. Member Appeal File Review 10 of 10 NA		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 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)	Full - Includes review results for Member Appeals if expedited This requirement is addressed in CP 5.20, and communicated to members in the Member Handbook on page 38 and also in letter template. Member Appeal File Review 10 of 10 NA		Includes file review results for member appeals, if expedited.	
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 is addressed in the member handbook on page 39. Member Appeal File Review 10 of 10 NA		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**
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 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	Full - This requirement is addressed in CP 5.20. This information is communicated to members in the Member Handbook on page 39. New Requirement	Full	This requirement is addressed in the CP 5.20 Member Appeals Policy on page 9 and is communicated to the members in the member handbook on page 34.	

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**
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 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	Substantial Includes file review summary results for Provider Grievances and Provider Appeals Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) Provider Post Service Medical Appeals Policy CP 5.12 and the Provider Manual Section page 70 detail policies and procedures for filing provider grievances and appeals. The subject report and desk audits were reviewed and no issues found. Reports 27, 28 and 29 were reviewed for the first 3 quarters of 2016 and all required information is included in the reports per the DMS requirements. Provider Grievance File Review	Substantial	Includes file review summary results for provider grievances and provider appeals. Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) This requirement is addressed in the Provider Post Service Medical Appeals Policy CP 5.12 and the provider manual. The subject report and desk audits were reviewed and no issues were found. **Provider Grievance File Review Results** Seven (7) of 10 files were resolved timely. One (1) of 10 files was not resolved timely. Two (2) of 10 files were not applicable. Seven (7) of 10 files contained a resolution letter that was fully compliant. One (1) of 10 files did not contain the investigation information for the grievance. Two (2) of 10 files were not applicable.	**Passport's Response** Passport Health Plan acknowledges receipt of IPRO's recommendation.

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 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.	1 of 1 non compliant. A resolution letter was not sent to the provider and evidence of timeliness could not be determined Provider Appeals File Review 10 of 10 were timely, included the nature of the appeal, date received and disposition Recommendation for Passport Passport should send a resolution letter with each grievance. **Passport's Response** Passport Health Plan has acted upon IPRO's recommendation by sending the Resolution Letters with each grievance. Passport also updated its Provider Letters to include the request of a 14 day extension		One (1) of 10 files contained a request for an extension; this file contained all requirements. **Provider Appeal File Review Results** Nine (9) of 10 files were fully compliant; 1 of 10 files was not applicable. **Recommendation for MCO** The MCO should resolve all grievances within the required timeframe and make sure that all investigations contain the required documentation.	
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	Full - Polices Provider Administrative Appeals and Provider Post Services Appeals partially address this requirement. It only states that a provider may appeal to a third party. The policy does not provide any further detail on how to submit the appeal. Final Review Determination The final review determination was changed to Full. Per DMS, the final	Full	This requirement is addressed in the provider manual and in the UM Program Description.	

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**
(60) days unless the Final Order designates a different timeframe.	policy was not due to DMS until 3/6/17. PHP met this deadline. New Requirement			
28.10 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Full - This requirement is addressed in the Provider Manual.			
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	Full	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) This requirement is addressed in reports #27, #28, and #29.	
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.	Deem for 2017	Full	This requirement is addressed in the Practitioner Office – Site Visits Related to Member Complaints Policy.	.

Final Findings

Grievance System
Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	2	0	0
Total Points	33	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		**2.85**		

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

Grievance System

Final Findings

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

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

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.	Full - These requirements are addressed in Health Risk Assessment (HRA) Management Policy No. CC 200 P.			
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.	Full - Includes HRA file review results. These requirements are addressed in Health Risk Assessment (HRA) Management Policy No. CC 200 P. HRA File Review 25 of 25 members had initial member packets provided to them. Only 3 members completed the HRA packet.		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.	Full - Includes HRA file review results. These requirements are addressed in Health Risk Assessment (HRA) Management Policy No. CC 200 P. on page 4. HRA File Review 25 of 25 a reasonable effort was made to contact the member, Only 3 members		Includes HRA file review results.	

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**
	completed the HRA packet.			
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/or any other health or community services.	Full - Includes HRA file review results This requirement is addressed in Health Risk Assessment (HRA) Management Policy Number CC 200 P, which includes the Adult Health Risk Assessment Form and the Pediatric Health Risk Assessment Form. HRA File Review 3 of 3 HRAs received contained the required information		Includes HRA file review results.	
The Contractor shall use appropriate healthcare professionals in the assessment process.	Full - This was addressed in Health Risk Assessment (HRA) Management Policy Number CC 200P which was updated to specify the role of health professionals in the assessment process. Passport provided a draft policy dated 12/30/16 that has been updated to reflect the requirement and can be considered during next year's review. <u>Recommendation for Passport</u> PHP should finalize the policy.	Full	IPRO Auditor for 2018 Review – Check policy CC 200P that was noted as draft. Make sure it is finalized. This requirement is addressed in the final Health Risk Assessment (HRA) Management Policy.	
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.	Full - This requirement is addressed in Health Risk Assessment (HRA) Management Policy Number CC 200 P, section 7.			
The Contractor shall submit a quarterly report on the	Full - Includes review of MCO Report #79 Health		Includes review of MCO Report #79 Health	

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**
number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.	Risk Assessments (see Quarterly Desk Audit results) The plan provided evidence of submission of MCO #79 quarterly reports for Q1, Q2 and Q3 2016, which include the required information.		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.	Deemed in 2017			
The Contractor shall be responsible for the management and continuity of health care for all Members.	Deemed in 2017			
The Contractor shall utilize a common HRA if one is designated by the Department.	Deemed in 2017			

Final Findings

Health Risk Assessment

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

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

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 Members 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 will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider	Full - This requirement, as it pertains to compliance with NCQA standards and the scope of credentialing, is addressed in the Practitioner Credentialing and Recredentialing Policy. Ongoing monitoring is addressed in the Ongoing Monitoring Desktop Procedure and in the Ongoing Monitoring of Sanctions Policy New Requirement	Substantial	This requirement is substantially addressed in the Practitioner Credentialing and Recredentialing Policy. Missing from this policy is the addition of the new requirement language pertaining to the 45-day requirement for substance abuse disorder services. **Recommendation for MCO** The MCO should add the full requirement language into its policies.	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. We have updated Policy NVR.010.E.KY – Practitioner Credentialing and Re-Credentialing to include the additional language  NVR.010.E.KY Practitioner Credo

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**
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:				
defining the scope of providers covered,	Full - This requirement is addressed in the Practitioner Credentialing Policy on page 2.			
the criteria and the primary source verification of information used to meet the criteria,	Full -This requirement is addressed in the Practitioner Credentialing Policy on page 3.			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Full - This requirement is addressed in the Practitioner Credentialing Policy on page 3. The Aperture Credentialing PSV and PHP Provider Enrollment Policy address primary source verification activities performed by Aperture.			

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 have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.	Full-This requirement is addressed in the Provider Review, Hearing and Appeal of Credentialing Matters Policy.			
Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.	Full - This requirement is addressed in the document Responsibilities of The CMO Or Designated Medical Director And The Credentialing Committee. This policy includes the specific provider types that serve as members of the Credentialing Committee.			
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.	Full-This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 1.			
The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The Contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy			

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.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy. This requirement is communicated to the provider in the Provider Manual.			
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
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.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy. This process is communicated to the providers in the Provider Manual.			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full - This requirement is addressed in the Evolent Delegation of Credentialing Functions Policy.			

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;	Full-This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
D. A credentialing committee which makes recommendations regarding credentialing;	Full -This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full - This requirement is addressed in the Delegation Process and in the Evolent Delegation of Credentialing Functions Policy.			
F. Written procedures for the termination or suspension of Providers; and	Full - This requirement is addressed in the Provider Termination and Suspension Policy and is communicated to the providers in the Provider Manual.			
G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Full - This requirement is addressed in the Provider Termination and Suspension Policy on page 2. Evidence of how the MCO implements this policy is found in the Provider Termination Desktop Procedure.			
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 Practitioner Credentialing Policy. Credentialing File Review Results		Includes credentialing file review summary results	

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**
	10 out of 10 files for credentialing were compliant with timeliness of review, had evidence of verification about sanctions and limitations, and information verified from the National Practitioner Data Bank (NPDB), Health and Human Services (HHS), Office of Inspector General (OIG), System for Award Management (SAM), and other monitoring organizations as required per specialty. 6 of 6 credentialing files showed a search for a valid DEA number as applicable, 4 were NA. 7 out of 10 files showed evidence of board certification, while the other 3 showed verification of educational training or medical degree, as required by regulation. 10 of 10 files had checked for imposed sanctions or liability claims. All credentialing files had written notification of the approval of the provider's credentialing application, and all were timely. Missing from the credentialing files was evidence of an initial visit to a potential provider as deemed necessary by the MCO. At the onsite file review discussion, it was discussed that provider onsite visits are not required for credentialing; onsite			

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**
	provider visits are conducted as needed to educate providers into Passport's provider network. At the onsite file review discussion, it was stated that licensure and credentials are verified during credentialing and every 3 years as required for recredentialing. The MCO receives ongoing reports of providers whose licenses have termed or have received sanctions. If the provider does not take action to renew their license, the credentialing review committee may terminate the provider. Verification requirements for providers addressing special health care needs of children under 21 needs to be discussed with DMS as this is not addressed in the MCO's current processes and procedures.			
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Full - This requirement is addressed in the Practitioner Credentialing Policy on page 2.			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full - This requirement is addressed in the Practitioner Credentialing Policy on page 2.			
C. Primary source of graduation from medical school and completion of an appropriate residency, or	Full - This requirement is addressed in the Practitioner Credentialing Policy on			

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**
accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	page 1.			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full - This requirement is addressed in the Practitioner Credentialing Policy on page 2.			
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;	Not Applicable The MCO discussed at the onsite audit those providers who service special needs individuals under 21 falls within the state's defined category of provider type 13. The provider who falls within this type 13 designation must have enrollment criteria that satisfy NCQA and state-listed requirements. The MCO contacted Aperture to verify if the regulation was part of the verification process for special needs providers that they must have graduate training or professional board certification in place to serve the special needs population. Aperture stated this regulation requirement is not currently met. IPRO will discuss this with DMS for resolution.	NA	Onsite, the MCO discussed those providers who service special needs individuals under the age of 21 years and fall within the state's defined category of "provider type 13." The providers who fall within this type 13 designation must have enrollment criteria that satisfy The National Committee for Quality Assurance (NCQA) and state-listed requirements. The MCO contacted Aperture to verify if the regulation was part of the verification process for special needs providers that they must have graduate training or professional board certification in place to serve the special needs population. Aperture stated this regulation requirement is not currently met.	
F. Previous five (5) years work history;	Full - The requirement that work history be included in the verification of a provider's credentials is addressed			

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 Practitioner Credentialing and Recredentialing Policy on page 3. The Primary Source Verification Services document provided at the onsite review proved that 5 years working history language is included as part of the verification policy.			
G. Professional liability claims history;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
I. Current, adequate malpractice insurance, as verified through attestation;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
K. Documentation of curtailment or suspension of medical staff privileges;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			

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**
M. Documentation of censure by the State or County professional association;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
N. Most recent information available from the National Practitioner Data Bank;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 3.			
O. Health and Human Services Office of Inspector General (HHS OIG); and	Full - This requirement is addressed in CR10.01 Ongoing Monitoring of Sanctions Policy and Procedure (UHC-CR 10.01) on page 2.			
P. System for Award Management (SAM).	Full - This requirement is addressed of the Aperture Credentialing PSV and Provider Enrollment Policy on page 3.			
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
B. Lack of present illegal drug use;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
C. History of loss of license and felony convictions;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
D. History of loss or limitation of privileges or disciplinary activity;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			

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**
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
F. Applicants attest to correctness and completeness of the application	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 2.			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Full - This requirement is addressed in the Office Site Visit Process.			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Full - This requirement is addressed in the Office Site Visit Process.			
The Contractor shall document an evaluation of the	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**
medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.	the Office Site Visit Process.			
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:	Full - Includes Recredentialing file review summary results This requirement is addressed in the Organizational Provider Recredentialing and Recredentialing Policy. Recredentialing File Review Results: 10 out of 10 files for recredentialing were compliant with the 3 year review requirement, had evidence of verification about sanctions and limitations, and information verified from the National Practitioner Data Bank (NPDB), Health and Human Services (HHS), Office of Inspector General (OIG), System for Award Management (SAM), and other monitoring organizations as required per specialty. 6 of 6 recredentialing files showed a search for a valid DEA number, 4 NA, as applicable, and all 10 files were checked for history of liability claims. The MCO stated that providers who are up for Recredentialing do not receive a written notice of recredentialing approval. However, providers are notified if they are		Includes recredentialing file review summary results.	

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**
	denied for recredentialing approval.			
A. A current license to practice;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
C. A valid DEA number, if applicable;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
F. A current signed attestation statement by the applicant regarding:	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
1. The ability to perform the essential functions of the position, with or without accommodation;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
2. The lack of current illegal drug use;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
3. A history of loss, limitation of privileges or any disciplinary action;	Full - This requirement is addressed in the Practitioner Credentialing and			

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**
	Recredentialing Policy.			
4. Current malpractice insurance;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
5. Health and Human Services Office of Inspector General (HHS OIG);	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
6. System for Award Management (SAM).	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
A. The national practitioner data bank;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
B. Medicare and Medicaid;	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
C. State boards of practice, as applicable; and	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			

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 have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
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, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.	Full - This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy.			
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.	Full - This requirement is addressed in the Practitioner Sanctions and Reporting Policy. This requirement is communicated to the providers through the Provider Manual.			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Full - This requirement is addressed in the Practitioner Sanctions and Reporting Policy.			
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.	Full - This requirement is addressed in the Practitioner Sanctions and Reporting Policy. The MCO notifies the Department regarding the facts and outcomes of a review by submitting an adverse action report.			

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 use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full - This requirement is addressed in the Provider Enrollment with the Department for Medicaid Services Policy.			
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 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	Substantial The requirement that the MCO's network include providers from the community is addressed in the Provider Enrollment Credentialing Verification Process. The listed provider types and specialties are addressed in the Provider Credentialing policy and Organization Provider Credentialing policies. The "any willing provider" statute is addressed in the Provider Contracting and Enrollment policy. Enrollment of FQHC and Rural health clinics is addressed in current policy for Organization Provider Credentialing but language addressing at least one is enrolled for each region where available is missing in the documentation. Providers that should be enrolled into the contractor's network are addressed in the Credentialing and Organization Credentialing Policies. The provider network was reviewed onsite with MCO staff for different	Substantial	The requirement that the MCO's network includes providers from the community is addressed in the Provider Enrollment Credentialing Verification Process. The listed provider types and specialties are addressed in the Provider Credentialing and Organization Provider Credentialing policies. The "any willing provider" statute is addressed in the Provider Contracting and Enrollment Policy. The requirement pertaining to enrollment of federally qualified health centers (FQHCs) and rural health clinics (RHCs) is addressed in the Organization Provider Credentialing Policy. Missing from the documentation is language in a policy or procedure that states the new requirement. Namely, that the plan 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 used by its members, whether the location provides	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. We have updated Policy PR 20.0 – Network Adequacy – Provider Recruitment to include the additional language.  PHP-PR-20.0 Network Adequac

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 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 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	provider types, most of which are listed in current policies and procedures, and some which were not. Speech pathologists were noted as Speech therapists to accommodate members. Peer support providers are not directly enrolled, but may exist within the enrolled Community Health centers. The provider network reviewed onsite also showed current enrollment of alcohol and drug counselors, or other provider specialties. The MCO's pharmacy vendor, CVS, addresses pharmacy provider type enrollment. The MCO stated new language requirements addressing chemical dependency provider types has not yet been incorporated into the existing policies and procedures since it is fairly new, but these provider types will be listed in policies and procedures going forward. Recommendation for Passport IPRO recommends that new updated requirement language be included in existing policies or procedures. For example, the exact language in the requirement that states "The Contractor shall enroll at least one (1)		physical access for its members with disabilities, and considers the numbers of network providers who are not accepting new Medicaid patients. **Recommendation for MCO** The MCO should add the full requirement language into its policies.	

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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, 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.	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", was missing in listed policies and procedures. Also, please include in policy and procedures for provider enrollment all listed provider types and specialties listed in the contract requirement since the MCO is actively enrolling these providers. <u>Passport's Response:</u> Passport Health Plan has acted upon IPRO's recommendation by updating our Policy to include that 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. Passport previously submitted and provided Policy PC 83.0 – Provider Contracting and Enrollment, which lists all provider types and specialties.			
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	Full - This requirement is addressed in the Provider Manual on page 79.			

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Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.				
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.	Full - This requirement is addressed in the Organizational Provider Credentialing and Recredentialing Policy. The requirement that the MCO's policies and procedures not discriminate against providers who serve high-risk populations or who specialize in conditions that require costly treatment is addressed in the Provider Manual at page 21.			
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.	Full - This requirement is addressed in the Provider Manual on page 26.			
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.	Full - This requirement is addressed in the Electronic Health Record Incentive documentation.			
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.	Full - This requirement was fulfilled by looking at the Provider Contracting and Enrollment Policy and also the Non-Participating Provider Claims Set-Up (which defined the method by which claims are processed).			

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**
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 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	Deemed in 2017	Full	This requirement is addressed in the Practitioner Credentialing and Practitioner Recredentialing Policy.	

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**
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, 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.	Full - This requirement is addressed in the Provider Enrollment with the Department for Medicaid Services Policy.			
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-	Full - This requirement is addressed in the Provider Enrollment with the Department for Medicaid Services Policy. This requirement is communicated to the providers in the Provider Manual.			

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**
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 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.	Full - This requirement is addressed in the Termination and Suspension Policy.			
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	Full - This requirement is addressed in the Provider Termination both Voluntary and Involuntary Policy.			

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**
receipt of notice by the Department.				
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.	Full - This requirement is addressed in the Provider Termination both Voluntary and Involuntary Policy.			
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.	Full - This requirement is addressed in the Termination and Suspension Policy.			
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.	Full - This requirement is addressed in the Provider Termination both Voluntary and Involuntary Policy.			
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.	Full - This is addressed in the policy Coordination of Care due to Provider Termination both Voluntary and Involuntary Member template letter and sample report of members seen with one terminated provider last six months were provided at the onsite visit to			

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**
	show compliance with the regulation.			
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.	Full - This requirement is addressed in the Provider Agreement.			
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) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.	Full - This requirement is addressed in the policy Coordination of Care Due to Provider Termination Both Voluntary and Involuntary.			

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	1	2	0	0
Total Points	3	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		**2.33**		

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.	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
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.	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's				

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**
policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
D. Discussing Advance Medical Directives with all Members as appropriate;	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;	Full - This requirement is addressed in the Provider Manual on page 45 under the section The Role of the Primary Care Provider.			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full - This requirement is addressed in the Provider Manual on page 46 under the section The Role of the			

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**
	Primary Care Provider.			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full - This requirement is addressed in the Provider Manual on page 46 under the section The Role of the Primary Care Provider.			
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.	Full - This requirement is addressed in the Provider Manual on page 46 under the section The Role of the Primary Care Provider. It is also addressed on page 54 under the section Office Standards and After-Hours Telephone Coverage.			
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone Coverage.			
(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	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone			

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**
maximum of thirty (30) minutes; and	Coverage.			
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone Coverage.			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone Coverage.			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone Coverage.			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone Coverage.			
(4) Returning after-hours calls outside of thirty (30) minutes.	Full - This requirement is addressed in the Provider Manual on page 54 under the section After-Hours Telephone Coverage.			
29.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all covered services are	Full - This requirement is			

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**
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.	addressed in the PCP Contract on page 3 and 5.			
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.	Substantial-The submitted documentation, including the access and appointment availability standards, does not directly specify this requirement, but does include the access standards, e.g., rural hospital within 60 miles or 60 minutes. Report "PP_Reports_160729_Report12A.pdf" provides a detailed analysis of Provider availability and accessibility by location and provider type and reports compliance with standards for distance in miles from member residence. Report 12A and the Access and Availability Standards policy mostly address the requirement. Some provider types and services are not clearly referenced within the existing policies such as dental, pharmacy, lab, vision	Full	This requirement is addressed in the Access and Availability Standards Policy. GeoAccess Network Report #12A also addresses this requirement.	

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**
	and radiology providers. Recommendation for Passport Passport should include access and availability standards for dental, pharmacy, vision, lab and radiology into the existing policy Access And Availability Standards. **Passport's Response:** Passport Health Plan has acted upon IPRO's recommendation by including access and availability standards for dental, pharmacy, vision, lab and radiology into existing Policy PR 13.0 - Access and Availability Standards. Passport Health Plan will also update Report 12a to include Geo Maps and the analysis will include the specific provider types, dental, pharmacy, vision, lab and radiology			
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:	Full-This requirement is addressed in the policy Access and Appointment Availability Standards. New Requirements	Full	This requirement is addressed in the Access and Availability Standards Policy.	
A. Primary Care Provider (PCP) delivery sites that are: no	Full Includes review of		Includes review of MCO Report #12A	

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**
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.	MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the policy Access and Appointment Availability Standards. Report 12A for July 2016 provides a detailed analysis of Provider availability and accessibility by location and provider type and reports compliance with standards for distance in miles from member residence.		GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	
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.	Full-This requirement is addressed in the policy Access and Appointment Availability Standards.			
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.	Full - Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) The Access and Appointment Availability Standards Policy and Procedures specify "Specialists shall not exceed sixty (60) miles or sixty (60)	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Standards Policy. GeoAccess Network Report #12A also addresses this requirement.	

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. In the event there are less than five (5) qualified Specialists in a particular Medicaid Region, the twenty-five (25%) shall not apply to that Medicaid Region." Report 12A for July 2016 provides a detailed analysis of Provider availability and accessibility by location and provider type and reports compliance with standards for distance in miles from member residence. Provider Network Adequacy Policies were provided onsite which meet the spirit of addressing the MCO identification and correction of provider network deficiencies New Requirements			
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.	Substantial The policy On Emergency Care and 24 Hour Access to Utilization Review Staff mostly addresses this requirement. Recommendation for	Full	This requirement is addressed in the Access and Availability Standards Policy. This requirement is also addressed on page 24 of the UM Program Description.	

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**
	Passport: Please update the existing policy to include procedures and requirement language for treatment of 'Emergency Substance Abuse Disorders'. **Passport's Response:** Passport Health Plan has acted upon IPRO's recommendation to update the existing Policy to include the required language for the treatment of Emergency Substance Abuse Disorders.			
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.	Substantial-Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) This requirement is addressed in the policy Access and Appointment Availability Standards. Report 12A for July 2016 provides a detailed analysis of Provider availability and accessibility by location and provider type and reports compliance with standards for distance in miles from member residence (using 30	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Standards Policy. GeoAccess Network Report #12A also addresses this requirement.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	miles for urban and 45 miles for rural). The report does not include minutes. Recommendation for Passport Listed regulation states that access in non-urban areas may not exceed sixty (60) minutes, and does not give the MCO the option of accessibility in miles. Please address accessibility language in reports and policies. **Passport's Response** Passport Health Plan has acted upon IPRO's recommendation to update and include in Report 12a, the accessibility in miles (distance measures) and time. **DMS Response** DMS is noting that Passport's Response does not specify regarding policies, as is commented on by IPRO in IPRO's Recommendation.			
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.	Substantial-Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results)	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The Access and Appointment Availability Standards Policy and Procedures specify "Specialists shall not exceed sixty (60) miles or sixty (60) minutes. In the event there are less than five (5) qualified Specialists in a particular Medicaid Region, the twenty-five (25%) shall not apply to that Medicaid Region." Report 12A for July 2016 provides a detailed analysis of Provider availability and accessibility by location and provider type and reports compliance with standards for distance in miles from member residence (using 30 miles for urban and 45 miles for rural). The report does not include minutes. Recommendation for Passport Although Report 12A indicates access to dentists, Passport should include the requirement language for access standards for dental services in the existing policy for Access and Availability		and Availability Standards Policy. GeoAccess Network Report #12A also addresses this requirement.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Standards. **Passport's Response:** Passport Health Plan has acted upon IPRO's recommendation to update the existing Policy PR 13.0 – Access and Availability Standards, to include access and availability standards for dental services. Passport Health Plan will also update Report 12a to include Geo Maps and the analysis will include the specific provider type, dentists. New Requirement			
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 Access and Appointment Availability Standards Policy and Procedures specify "Specialists shall not exceed sixty (60) miles or sixty (60) minutes. In the event there are less than five (5) qualified Specialists in a particular	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Standards Policy. GeoAccess Network Report #12A also addresses this requirement.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Medicaid Region, the twenty-five (25%) shall not apply to that Medicaid Region." This document also specifies 30 days for routine appointments and 48 hours for urgent appointments in reference to Specialist Care Providers. Report 12A for July 2016 provides a detailed analysis of provider availability and accessibility by location and provider type. This reports compliance with standards for distance in miles from member residence for vision providers. Access Standards on page 3 of the policy Access and Availability Standards are not specified for dental, lab, pharmacy, vision and radiology providers. However, Report 12A showed dental, vision and pharmacy access standards are 30 miles for urban areas and 45 miles for rural areas. Recommendation for Passport			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Passport should update the existing Access and Availability standards Policy to address access standards specifically for dental, pharmacy, vision, and laboratory and radiology service providers. If these providers are grouped under 'Other' type providers, the MCO should state this in their policy. **Passport's Response:** Passport Health Plan has acted upon IPRO's recommendation to update the existing Policy PR 13.0 – Access and Availability Standards, to include access and availability standards for dental, pharmacy, vision, laboratory and radiology service providers.			
H. Access for Pharmacy services shall not exceed Thirty (30) miles or thirty (30) minutes.	Substantial-Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) This requirement does not appear to be addressed in the submitted documentation, although the policy Access and Availability Standards specify "Specialists shall not exceed	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Standards Policy. GeoAccess Network Report #12A also addresses this requirement.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	sixty (60) miles or sixty (60) minutes". Report 12A for July 2016 provides a detailed analysis of provider availability and accessibility by location and provider type and reports compliance with standards for distance in miles from member residence. Recommendation for Passport Passport should update the existing Access and Availability standards Policy to address access standards specifically for dental, pharmacy, vision, and laboratory and radiology service providers. If these providers are grouped under 'Other' type providers, the MCO should state this in their policy. **Passport's Response** Passport Health Plan has acted upon IPRO's recommendation to update the exiting Policy PR 13.0 – Access and Availability Standards to include access and availability standards for dental, pharmacy, vision, laboratory and radiology			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	service providers. New Requirement			
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 residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services.	Full - The MCO showed that they enroll mental health and substance abuse providers that provide services listed in the requirement.			
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.	Full - At the onsite audit, staff discussed that Emergency Room (ER) Navigators do inform members of alternate sites. Additional documentation and policies that addressed the requirement were the ER Navigator Coordinator procedure document, the Reduction in Emergency Room Utilization document, and Emergency Care and 24 Hour Access to Utilization Review Staff document.			
29.8 Additional Network Provider Requirements				
A. The Contractor shall attempt to enroll the following				

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Providers in its network as follows:				
1. Teaching hospitals;	Full - The December 2016 Commission for Children - All ER Visits – Monthly document includes teaching hospitals.			
2. FQHCs and rural health clinics;	Full - Report 12A provides a detailed analysis of Provider availability and accessibility by location and provider type. For FQHC's and rural health clinics, the report specifies a total of 211 providers at 207 locations. The access standard was met for 99.7% of urban and 100.0% or rural members. The document provided, titled Section 29.8, includes a list of FQHCs and RHCs.			
3. The Kentucky Commission for Children with Special Health Care Needs; and	Full - This requirement listed is not a provider type or group. Staff explained at the onsite audit that providers who are willing to address the special health care needs populations are actively enrolled.			
4. Community Mental Health Centers	Full - The excel document Section 29.8 includes a list of Community Mental Health Centers. This requirement is addressed			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	in documentation for Provider Credentialing policy.			
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.	Full - This requirement is addressed in the document Non-Participating Provider Claims Set-Up.			
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 907 KAR 1:360.	Full - This item was addressed by a sample specialty care provider agreement form.			
2. Provide reimbursement at rates commensurate with those provided under Medicare.	Full - This item is addressed by the various reimbursement procedure documents provided, e.g. Specialty Care Reimbursement procedure.			
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Full - The requirement states that MCOs may enroll providers who fall into this category. Providers who are seen as charitable may be health clinics or local health			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	departments, which the MCO actively enrolls.			
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.	Full - The Managed Care Accessibility Analysis documents this requirement; for example, addresses that there be sufficient numbers of the following provider types that traditionally provide a significant level of care to Medicaid members: PCP, hospital, pharmacy, dental. The excel file Section 29.8 includes a list of facilities for Acute Care, Commission for Handicapped Children, Community Mental Health Centers, FQHCs, and RHCs.			
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.	Full - Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) - The Managed Care Accessibility Analysis documents this requirement; for example, addresses that there be sufficient numbers of the following provider types that traditionally provide a		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	significant level of care to Medicaid members: PCP, hospital, pharmacy, dental. The MCO discussed at the onsite audit that there were no significant changes to the provider network this past year.			
The Contractor shall update this information to reflect changes in the Contractor's Network monthly.	Full - There were no significant changes to the provider network this year.			
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 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.	Full - Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results) Quarterly Report 13 provides descriptive information on access issues. Report 13 for Quarter 1 indicates no provider complaints and 60 member complaints, with 23 related to access. All member grievances were recorded, investigated, and resolved. The only reported gap was for Psychiatrists, Rural, with a compliance rate		Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results).	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	of 99.9% of members with access within 45 miles. Report 13 for Quarter 2 indicates no provider complaints and 59 member issues, with 23 related to access. All member grievances were recorded, investigated, and resolved. The only reported gap was for Psychiatrists, Rural, with a compliance rate of 99.9% of members with access within 45 miles. Report 13 for Quarter 3 indicates that no provider complaints were made and that 12 member complaints were received, with all 12 related to access. All member grievances were recorded, investigated, and resolved. No gaps were reported. The Network Adequacy Provider Recruitment Policy was provided at the onsite, and satisfied the requirement of the regulation.			
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based	Full - The Network Adequacy Provider Recruitment Policy was provided at the onsite,			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	and satisfied the requirement of the regulation.			
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 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	Full - The PCP and Specialist contracts include language: "Provider agrees that all covered services shall be as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members." Additionally, a summary of Member benefits lists the services covered. Policies and procedures are in place for utilization management and case management that address the spirit of this requirement. New Requirement	Full	The PCP and Specialist contracts include the required language. Transition and Continuity of Care Policy addresses continuity of care for members with ongoing or chronic conditions.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Full - The document Transition and Continuity of Care addresses continuity of care for members whose benefits are exhausted.			
The Contractor may provide, or arrange to provide, services in addition to the services described above, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Full - Requirement met per policy of the Mommy Steps Program. The policy addressed referrals to HANDS, WIC, and Healthy Start. Staff at the onsite audit explained medically necessary services receive DMS approval prior to enactment. These services may be paid for by the MCO.			
For any Medicaid service provided by the Contractor that	Full - This requirement is			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	addressed in the Provider Manual on page 56.			
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.	Full - This requirement is addressed in the Provider Manual on page 48.			
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.	Full - The Provider Manual on page 45 includes a statement on PCP responsibility: "Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within Passport's network. At the onsite audit, the requirement was addressed with staff that if a covered service cannot be rendered, Utilization Management will assist the member's continuity of care to an out of network provider. The Member Handbook on page 23 specifies: "If there is			

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	not a network provider available to provide you a covered service, we will pay for your visit to an out-of-network provider if medically necessary."			
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.	Substantial-The Member Handbook on page 22 specifies: "Your primary care provider (PCP) will help you choose a specialist for your condition." 'The Passport Promise' makes reference to members' ability to choose within the MCO network of providers. Recommendation for Passport Passport should update the member handbook's existing language to reflect member's right to choose specialist within the MCO network.	Full	This requirement is addressed in the member handbook on page 21.	
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.	Substantial-The PR 13.0 Access and Appointment Availability Standards and the Provider Manual on page 90 address this requirement, with the exception of the Post	Full	This requirement is addressed in the Access and Availability Standards Policy and in the provider manual.	

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Stabilization Care services. Regarding Post Stabilization services, this document only specifies: "Emergency Care with Crisis Stabilization" for Behavioral Health Services. Recommendation for Passport Passport should update the existing policy on Emergency Care and 24 Hour Access to Utilization Review Staff policy to address post-stabilization services. Also include this information in the Member Handbook. **Passport's Response:** Passport Health Plan has acted upon IPRO's recommendation by including the requirement information in Passport's online Member Handbook. This information will be included via a hard copy in the 2018 Member Handbook. New Requirement			
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	Full - The Provider Manual and Member Handbook address this requirement, although it			

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 42 CFR 438.114.	specifies outside service area instead of outside network. The Provider Manual on page 89 specifies: "Emergency care as described in Section 10.1.1 is also a covered benefit for Passport members when they are out of the service area. A referral or prior authorization is not required for out-of-service- area emergency care in the ER. For an out-of-network provider to receive reimbursement a Kentucky Medicaid ID number and Passport Provider ID number is needed. " The Member Handbook on page 23 specifies: "Emergency care is covered for you inside and outside the service area. If you are out of the service area and have a true emergency, please go to the nearest emergency room. A true emergency is when you think a medical situation is a threat to your life or long term health if you don't get care right away." The policy Provider			

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**
	Contracting and Enrollment includes a note to provide emergency services to non-participating providers.			
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.	Full - Policy and Procedure for Hospital reimbursements were provided after the onsite audit. The requirement was listed in listed policies. The policy Provider Contracting and Enrollment specifies: "Non-Participating providers will be paid on the established non-par fee schedule or, when negotiated separately, the established Letter of Agreement".			
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	Full - This requirement is addressed in the Network Adequacy policy document and also in the policy Out of Network Providers. Procedures are in place for members who want to receive Primary care services from an out of network physician.			

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**
necessary enrollment procedures have been completed.				
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Full - The Provider Manual on page 69 addresses this requirement.			
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Full - The Provider Manual on page 69 addresses this requirement.			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full - The Provider Manual on page 69 addresses this requirement.			
D. Maternity care for Members under 18 years of age;	Full - The Provider Manual on page 69 addresses this requirement.			
E. Immunizations to Members under 21 years of age;	Full - The Provider Manual on page 69 addresses this requirement.			
F. Sexually transmitted disease screening, evaluation and treatment;	Full - The Provider Manual on page 69 addresses this requirement.			
G. Tuberculosis screening, evaluation and treatment;	Full - The Provider Manual on page 69 addresses this requirement.			
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as	Full - The Provider Manual on page 69 addresses this			

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**
defined by 902 KAR 2:020;	requirement.			
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 provider manual on page 70.	
K. Women's health specialists.	Full - The Provider Manual on page 69 addresses this requirement.			
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 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.	Full - The Provider Manual on page 69 addresses this requirement.			
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.	Full - The Provider Manual on page 109 addresses this requirement.			
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	Full - The Provider Manual on page 54, and the PCP and Specialist contracts address			

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 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.	this requirement.			

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	12	0	0	0
Total Points	36	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: 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
- Behavioral health services including mental health and substance abuse providers

Final Findings

- 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: Passport Health Plan

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.	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 3.			
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 5. The MCO ensures compliance with UM standards for the following delegated services: Behavioral Health (Beacon Health Strategies), Pharmacy (Magellan), General Dentistry (Avesis), General Vision (Superior Vision), High Dollar Radiology (EviCore).			
The description shall include the scope of the program;	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description.			
the processes and information sources used to determine service coverage;	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description.			

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**
clinical necessity, appropriateness and effectiveness;	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description.			
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Full This requirement is addressed in the policies Review Process, Desktop Procedure Cultural Competence, and Discharge Planning. All requirements also addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description.			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Full-This requirement is addressed in the policies Review Process, Desktop Procedure EPSDT Special Services and Passport Health Plan 2016 Utilization Management and Clinical Programs Description.			
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.	Full-The requirement is addressed by Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 4 and 5. It is also addressed by policy and procedure Passport Health Plan 2015 Utilization Management & Clinical Programs Evaluation.			
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	Full-The requirement is addressed by Passport Health Plan 2016			

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**
the Medical Director, the Behavioral Health Director, or the Medicaid Commissioner.	Utilization Management and Clinical Programs Description on page 4 and 5. It is also addressed by policy and procedure Passport Health Plan 2015 Utilization Management & Clinical Programs Evaluation.			
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 ninety (90) days to implement criteria the	Full-The Passport Health Plan 2016 Utilization Management and Clinical Programs Description states on page 10 that InterQual criteria are utilized for medical necessity review of requested adult and pediatric services. Reference to ASAM is made in the Beacon Triage and Referral Manual MK AM document. Additional approvals for any modification to existing UM programs or policies requiring approval from DMS is mentioned on page 5 of the 2016 Utilization Management and Clinical Programs Description. New Requirement	Full	This requirement is addressed in the 2018 Passport Utilization Management Program Description on page 10.	**Passport's Response** Passport Health Plan has added this information to the 2018 Passport Utilization Management Program Description, Section II. Medical Policy, Page 10: *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 ninety (90) days to implement criteria the Department may otherwise require* (highlighted in yellow). 2018 Passport Utilization Mng Pr

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**
Department may otherwise require.				
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 14, and is additionally addressed by Interrater Reliability Testing Combined CP 30.00 Medical Director Consistency Review, 2015 Annual RN IRR Medical Consistency Review Report, and 2015 Annual Medical Doctor IRR Review Report. See the subsequent Requirement/Comments (page 6-7 of this review tool) regarding evidence of monitoring consistent application of review criteria by Behavioral Health (Beacon), Dental (Avesis), Advanced Radiology (EviCore), and Pharmacy (Magellan) personnel.			
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Full - Includes UM file review results This requirement is addressed in UM 35.00 Review Process (page 6-7, 10). UM File Review Results: All 10 files showed a clinical		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**
	reviewer was involved, and where applicable, consultation with the attending provider or peer to peer review notes was noted in the provided documentation.			
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.	Full - Includes UM file review results This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description (page 26). UM File Review Results: All 10 UM files showed compliance with the listed regulation.		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 UM 11.01 Denial of Services Based on Lack of Medical Necessity (page 5), Passport Health Plan 2016 Utilization Management and Clinical Programs Description (page 27). UM File Review Results: 10 out of 10 UM files showed compliance with the listed regulation.		Includes UM file review results.	
Physician consultants from appropriate medical, surgical and psychiatric specialties shall be	Full This requirement is addressed in			

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**
accessible and available for consultation as needed.	Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 26.			
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.	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 19 and 20. New Requirement	Substantial	Includes UM file review results. This requirement is addressed in the 2018 Passport Utilization Management Program Description. Pages 19–20 detail the inpatient pre-admission and urgent review requests, and page 22 details post-service review requests. **File Review Results** Seven (7) of 10 files were applicable for review, since the denial in these 7 cases pertained to medical necessity. Five (5) of 7 files demonstrated timeliness. The 2 files with timeliness issues were processed by Evicore. The MCO has scheduled a meeting with this vendor to discuss timeliness, in response to ongoing issues. Re-education of Evicore took place in September 2018. Going forward, The MCO will conduct an audit each month, wherein they will request a random sample to perform quality assurance/quality control (QA/QC). The MCO indicated they will use the National Committee for Quality Assurance (NCQA) and IPRO compliance tool to monitor this vendor. This audit is anticipated to begin on December 1, 2018. **Recommendation for MCO** The MCO should continue monitoring Evicore, and ensure all review requests and denial decisions are made within the appropriate	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. A request has been sent to the Subcons for Random audits to be conducted each month. The Subcon is to send case listings and Passport will select 5 cases including both approvals and denials to ensure case decisions are rendered within required timeframe.

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**
			timeframes.	
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Full-This requirement is addressed in Desktop Procedure Utilization Management Program Modifications on page 2), Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 17 and 24.			
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.	Full-The Passport Health Plan 2016 Utilization Management and Clinical Programs Description refer to "annual assessments of delegated entities to ensure NCQA and contractual compliance for activities related to Utilization Management". This requirement is met through the service agreement contracts the MCO has with Avesis, CVS, Beacon, Superior and Xerox.			
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 Responsibilities.	Full-This requirement is addressed in the Review Process policy on page 8. Upon request, written confirmation of an approval notification is provided within one business day.			
D. The Contractor shall have written policies and procedures that show how the Contractor will	Full-This requirement is addressed in the policy Out of Network 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**
monitor to ensure clinical appropriate overall continuity of care.	The policy is evaluated based on quality audits to assess the application of continuity of care criteria, as well as quantitative analysis of the number and types of OON requests, approvals and denials.			
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	Substantial	This requirement is partially addressed in the 2018 Passport Utilization Management Program Description on pages 22–24 and in UM.901.E.KY Discharge Planning. There is an opportunity to incorporate language from the regulation, specifying coordination of services for those members who receive services from another MCO or fee-for-service (FFS), for instance. **Recommendation for MCO** The MCO should include this requirement in the UM program description, to help ensure that the MCO coordinates services across various settings and in collaboration with key stakeholders.	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. This information has been added to the 2018 Passport Utilization Management Program Description, Section IX. Utilization Management Activities, Page 23: Coordination of Services (highlighted in Yellow). See previous attachment.
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.	Full-This requirement is addressed in Utilization Management Program on page 4 and Passport Health Plan 2016 Utilization Management and Clinical Programs Description policy on page 24.			
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208,	Full--This requirement is addressed in Passport Health Plan 2016			

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**
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.	Utilization Management and Clinical Programs Description on page 24, which states "Passport Health Plan's policy on non-compensation for decision makers is communicated to providers and members through the Passport Health Plan Provider Manual, the Member Handbook, and on Passport Health Plan's website. All Passport Health Plan staff is required to sign a Code of Conduct, which addresses this, on an annual basis."			
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Full--This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description on page 4 and 17. It is also addressed on Passport Health Plan 2015 Utilization Management & Clinical Programs Evaluation on page 16 to 28.			
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.	Full-This requirement is addressed in Passport Health Plan 2016 Utilization Management and Clinical Programs Description.			
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Full-This requirement is addressed in Passport Health Plan 2015 Utilization Management & Clinical Programs Evaluation on page 41, and in Passport Health Plan 2015			

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**
	Quality Improvement Evaluation.			
The UM program will be evaluated by the Department on an annual basis.	Full-Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results) This requirement is addressed in Utilization Management Program on page 4, and in monthly submissions of Report #59 Prior Authorizations.		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				
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any 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:	Full-This requirement is addressed in Denial of Services Based on Lack of Medical Necessity on page 5.			
A. The adverse benefit determination the Contractor has taken or intends to take;	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 5. UM File Review Results: All 10 UM files sampled met compliance for this requirement		Includes UM file review results.	
B. The reasons for the adverse benefit determination in clear, non-technical language that is understandable by a layperson;	Full - Includes UM file review results This requirement is addressed in		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**
	Denial of Services Based on Lack of Medical Necessity policy on page 5. UM File Review Results: All 10 UM files sampled met compliance for this requirement			
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, including medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	New Requirement	Full	Includes UM file review results. This requirement is addressed in the 2018 Passport Utilization Management Program Description on page 28 and in the Denial of Services Based on Lack of Medical Necessity Policy on page 16. **File Review Results** Ten (10) of 10 files met this requirement.	
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	Full	Includes UM file review results. This requirement is addressed in the 2018 Passport Utilization Management Program Description on page 28. **File Review Results** Seven (7) of 10 files reviewed related to a denial of a service based on lack of medical necessity. Of these 7 files, all contained specific and detailed information as to why the service did not meet medical necessity.	
E. The federal or state regulation supporting the action, if applicable;	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of		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**
	Medical Necessity policy on page 5. UM File Review Results: For the UM that were medical denials to members (6 /6 compliant, 4 NA), the federal regulation was listed on the member letter.			
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);	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 5. UM File Review Results: For the UM that were medical denials to members (6 /6 compliant, 4 NA), the member's right to appeal was addressed in the denial letter. New Requirement	Full	Includes UM file review results. This requirement is addressed in the 2018 Passport Utilization Management Program Description on page 28. There is no specific reference to exhausting the one level of appeal; however, it is evident in the language used that there is only one level, and then the case is referred to the state for a state fair hearing. This requirement is also addressed in the Denial of Services Based on Lack of Medical Necessity Policy on page 7. **File Review Results** Ten (10) of 10 files met this requirement.	
G. The Member's right to request a State hearing after receiving notice that the adverse benefit determination is upheld;	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 5. UM File Review Results: For the UM that were medical denials to members (6 /6 compliant,	Full	Includes UM file review results. This requirement is addressed in the 2018 Passport Utilization Management Program Description on page 28 and in the Denial of Services Based on Lack of Medical Necessity Policy on page 7. **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**
	4 NA), the member's right to a state hearing was addressed in the denial letter. New Requirement		Ten (10) of 10 files met this requirement.	
H. Procedures for exercising Member's rights to Appeal or file a Grievance;	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 6. UM File Review Results: For the UM that were medical denials to members ((6 /6 compliant, 4 NA), the member's right to an appeal was addressed in the denial letter.		Includes UM file review results.	
I. Circumstances under which expedited resolution is available and how to request it;	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 6. UM File Review Results: This item was addressed in the denial letters to members.		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.	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 6.		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**
	UM File Review Results: This item was addressed in all the denial letters to members.			
K. Be available in English, Spanish, and each non-English language;	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 6. UM File Review Results: This item was addressed in all the denial letters to members. New Requirement	Full	Includes UM file review results. This requirement is addressed in the 2018 Passport Utilization Management Program Description on page 28 and in the Denial of Services Based on Lack of Medical Necessity Policy on page 8. On site, the MCO indicated that language is identified from the state eligibility file, but if there is a correction, they will create a language preference, so that when the eligibility file is updated this language preference will remain in the MCO's system. Further, the MCO noted collaboration with Case Management to better identify member's preferred language. **File Review Results** Ten (10) of 10 files met this requirement.	
L. Be available in alternative formats for persons with special needs; and	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 6. UM File Review Results: This item was not applicable for any of the UM files reviewed.		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.	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 5.		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.	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
B. The Contractor must give notice by the date of the adverse Action for the following:				
1. In the death of a Member;	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
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);	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
3. The Member's admission to an institution where he is ineligible for further services;	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Full This requirement is addressed in			

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**
	Denial of Services Based on Lack of Medical Necessity policy on page 3.			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
6. The Member's physician prescribes the change in the level of medical care;	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.	Full This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
C. The Contractor must give notice on the date of the adverse Action when the Action is a denial of payment.	Full-This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 3.			
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,	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 4.		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**
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.	UM File Review Results: Some of the UM files reviewed were for payments or coverage of services after they were rendered to the member or prior to the member's visit. For those with denial notices during the time period of the member's service, timeliness of the MCO's notice was met.			
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.	Full - Includes UM file review results This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 4. UM File Review Results: None of the UM files reviewed had a notice of extension requested by member or rendering provider. New Requirement	Substantial	Includes UM file review results. This requirement is addressed in the Denial of Services Based on Lack of Medical Necessity Policy on page 5. This requirement is also addressed in CP.520.E.KY Member Appeals on page 7. This requirement is minimally addressed in the 2018 Passport Utilization Management Program Description on page 32, which states that the MCO will send the member written notice of the extension within 2 *working* days of the decision to extend. The member handbook also includes reference to 2 working days. **File Review Results** None of the 10 files reviewed contained an extension request; therefore, none were applicable for this requirement. **Recommendation for MCO** The MCO should revise both the UM program	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. This information has been added to the 2018 Passport Utilization Management Program Description, Section XII. Appeals : Changed to 2 Calendar days from 2 working days noted on page 30 and added the following language to Page 31: *The Appeals Department will notify the member orally of the Plan's intent to extend the appeal time frame and provide the member with the right to file a grievance if they disagree with decision to extend.* **(highlighted in yellow)**. Request has been sent to our Marketing Department to update Page 35 of the Member Handbook to reflect Calendar days. See previous attachment.

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**
			description and the member handbook to reflect 2 *calendar days*, in reference to when they will send the member written notice of an extension. Furthermore, the MCO should reference the intent to notify the member orally in both of these documents, in addition to providing them with the right to file a grievance if they disagree with decision to extend. While on site, the MCO updated the UM program description to reflect 2 calendar days and the intent to notify member orally in the event of an extension.	
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.	Full-This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 4.			
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.	Full-This requirement is addressed in Denial of Services Based on Lack of Medical Necessity policy on page 4.			
21.4 Prior Authorizations				
The Department shall provide a common Prior Authorization Form for all Contractors to utilize for a Provider to initiate its prior authorization process.				

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**
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: Passport Health Plan

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	6	3	0	0
Total Points	18	6	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.67**		

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: Passport Health Plan

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.				
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 documents 2016 Program Integrity Plan, and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse. The requirement is addressed in the MCO document 2016 Compliance Program.	Full	This requirement is addressed in the Compliance Program and the Program Integrity Plan.	
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;	Full - The requirement is addressed in document 2016 Program Integrity Plan on page 2 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 1 and 2. The requirement is addressed in the MCO document 2016 Compliance Program.	Full	This requirement is addressed in the Compliance Program, the Program Integrity Plan, and in the Prevention, Detection and Investigation of Fraud, Waste, and Abuse Policy.	
B. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1 and Organizational Chart 11.21.2016 which shows that the VP & Chief Compliance	Full	This requirement is addressed in the Program Integrity Plan and in the organizational charts provided.	

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**
contract and who reports directly to the Chief Executive Officer and the Board of Directors;	Officer reports to the Plan's CEO. The requirement is addressed in the MCO document 2016 Compliance Program. The MCO submitted copies of the its Compliance Committee Meeting minutes dated 1/13/16, 4/14/16 and 7/13/16 which show that the VP & Chief Compliance Officer Director of Compliance were in attendance at all three meetings. These documents meet the requirement.			
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 Program on pages 4–5.	
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));	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 7, Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 8 and 9, and copies of employee certificates of completion of Fraud, Waste and Abuse training. The requirement is addressed in MCO document 2016 Compliance Program.	Full	This requirement is addressed in the Compliance Program on pages 9–11.	
E. Effective lines of communication between the Compliance Officer and the contractor's employees;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1, which notes the various methods of communication with all MCO associates	Full	This requirement is addressed in the Compliance Plan on pages 11–12 and in the Program Integrity Plan on page 2.	

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**
	including meetings, compliance training, compliance hotline and the MCO's intranet; also see Complaint System on page 5; and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9. The requirement is addressed in MCO document 2016 Compliance Program on page 9.			
F. Enforcement of standards through written and publicized disciplinary guidelines;	Full - The requirement is addressed in MCO document 2016 Compliance Program on page 8.	Full	This requirement is addressed in the Compliance Plan on page 16.	
F. Provision for internal monitoring and auditing of the member and provider;	Full - The requirement is addressed in documents 2016 Program Integrity Plan, Record Reviews (page 4), Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse (page 5) as well as Provider Audits (page 9) and Policy PI.3.00.E Provider Onsite Audits. The requirement is addressed in MCO document 2016 Compliance Program on page 5.	Full	This requirement is addressed in the Program Integrity Plan on page 5.	
G. Written procedures and an operational system that include but are not limited to the following:				
1. Routine internal monitoring and auditing of member, provider and compliance risks by dedicated staff for the Contractor and any Subcontractor;	New Requirements	Full	This requirement is addressed in the Compliance Plan on pages 12–15.	
2. Prompt investigation, response and development of corrective action initiatives to compliance risks or	New Requirements	Full	This requirement is addressed in the Compliance Plan on pages 15–16.	

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**
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;				
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 Requirements	Full	This requirement is addressed in the Compliance Plan on page 10.	
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 Requirements	Full	This requirement is addressed in the Desktop Procedure on page 6.	
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 Requirements	Full	This requirement is addressed in the Desktop Procedure on page 4.	
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 Requirements	Full	This requirement is addressed in the Provider Contract Template.	
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	New Requirements	Full	This requirement is addressed in the Desktop Procedure and in the Program Integrity Plan on page 7.	

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**
payment suspension information quarterly in a manner determined by the Department;				
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 Requirements	Full	This requirement is addressed in the Desktop Procedure on page 6.	
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 Requirements	Full	This requirement is addressed in the Desktop Procedure on page 6.	
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 Requirements	Full	This requirement is addressed in the Program Integrity Plan on page 9.	
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 Requirements	Full	This requirement is addressed in the Provider Enrollment with the Department for Medicaid Services Policy and in the Practitioner Credentialing and Re-Credentialing 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 Requirements	Full	This requirement is addressed in the Program Integrity Plan on pages 9–10.	
13. An appeal process;	New Requirements	Full	This requirement is addressed in the Desktop Procedure on page 7.	

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**
14. Process for card sharing cases;	New Requirements	Full	This requirement is addressed in the Program Integrity Plan on page 4.	
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 Requirements	Full	This requirement is addressed in the Prevention, Detection and Investigation of Fraud, Waste, and Abuse Policy.	
16. Tracking the disposition of all member and provider cases (initial and preliminary) as well as case management that allows for ad hoc reporting or case status	New Requirements	Full	This requirement is addressed in the Prevention, Detection and Investigation of Fraud, Waste, and Abuse Policy.	
17. A prepayment review process in accordance with this contract; and	New Requirements	Minimal	This requirement is addressed in the Desktop Procedure. The MCO has submitted a Prepayment Policy to DMS, which was not approved due to lack of information on how the process would be operationalized. The MCO is revising the policy and will resubmit for approval. **Recommendation for MCO** The MCO should submit its revised policy to DMS and begin implementation as soon as applicable.	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. A revised Prepayment Policy was submitted to DMS on 01/22/2019. Additional meetings will be scheduled surrounding next steps for implementation once DMS approval is received.
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	New Requirements	Non-Compliance	The MCO employs two full-time investigators. These investigators do not currently meet the experience requirement.	**Passport's Response** Passport Health Plan lost one of its full time investigators in October and DMS was notified within the required timeframe. Passport is in the process of interviewing and hiring an applicant for the vacant position. Passport has had discussions with DMS Program Integrity surrounding 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**
requirements in the interim.				staffing challenges.
H. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full - The requirement is addressed in documents 2016 Program Integrity Plan, Record Reviews (page 4), Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse (page 5) and Policy PI.3.00.E Provider Onsite Audits. The requirement is addressed in MCO document 2016 Compliance Program on page 9.	Full	This requirement is addressed in the Program Integrity Plan on page 7.	
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 were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 7 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9. The MCO provided monthly Report #73 Explanation of Member Benefits for the period of January 2016 through October 2016 which meets the requirement.	Full	This requirement is addressed in the Program Integrity Plan on page 8.	
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;	Full - Includes review of MCO Report #75 SUR Algorithms The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 4. The MCO provided monthly Report #75 SUR Algorithms for the period of January 2016 through October 2016 which meets the	Full	Includes review of MCO Report #75 SUR Algorithms. This requirement is addressed in the Desktop Procedure and in the Prevention, Detection, and Investigation of Fraud, Waste, and Abuse Policy.	

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**
	requirement.			
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 4. The MCO provided monthly Report #75 SUR Algorithms for the period of January 2016 through October 2016 which meets the requirement.	Full	This requirement is addressed in the Program Integrity Plan on pages 6–7.	
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	Minimal	This requirement is partially addressed in the Desktop Procedure. This procedure details the data elements that shall be included in the reporting to DMS. Missing from the documentation was language pertaining to the fifteen day requirement. The MCO has submitted a Prepayment Policy to DMS, which was not approved due to lack of information on how the process would be operationalized. The MCO is revising the policy and will resubmit for approval. **Recommendation for MCO** The MCO should submit its revised policy to DMS and begin implementation as soon as applicable.	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. A revised Prepayment Policy was submitted to DMS on 01/22/2019. Additional meetings will be scheduled surrounding next steps for implementation once DMS approval is received.
M. Contractor shall attend any training given by the Commonwealth, Department, its Fiscal Agent or other Contractor's organizations provided	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 7 and Policy PI.1.00.e Prevention,	Full	This requirement is addressed in the Program Integrity Plan on page 8 and in the Prevention, Detection, and Investigation of	

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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**
reasonable advance notice is given to Contractor of the scheduled training.	Detection and Investigation of Fraud/Waste/Abuse on page 8 and 9. The MCO submitted copies of the two emails regarding attending the Health Care Fraud Task Force Conference on 9/14/16 Additional documentation and discussions onsite provided proof of attendance and training as required.		Fraud, Waste, and Abuse Policy.	
The plan shall be made available to the Department for review and approval.	Full - The requirement is addressed in documents 2016 Program Integrity Plan.	Full	This requirement is addressed in the Program Integrity Plan.	
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.	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1 and Organizational Chart 11.21.2016 which shows that the VP & Chief Compliance Officer reports to the MCO's CEO.			

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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**
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 abuse of Medicaid services within Kentucky..	Full - The requirement is addressed in a copy of MCO staff which shows the MCO's KY address and shows the Plan's Program Integrity Coordinator. The requirement is also addressed in Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 3 which states that the Program Integrity Manager serves as the Program Integrity Unit Coordinator.			
37.2 Prepayment Review	New Requirement			
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.		Minimal	This requirement is partially addressed in the Desktop Procedure. The MCO has submitted a Prepayment Policy to DMS, which was not approved due to lack of information on how the process would be operationalized. The MCO is revising the policy and will resubmit for approval. **Recommendation for MCO** The MCO should submit its revised policy to DMS and begin implementation as soon as applicable.	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. A revised Prepayment Policy was submitted to DMS on 01/22/2019. Additional meetings will be scheduled surrounding next steps for implementation once DMS approval is received.
Notice shall be sent to the provider in writing on or		Minimal	This requirement is partially addressed in the	**Passport's Response**

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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**
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 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.			Desktop Procedure. This procedure contains the requirement that notice be sent to the provider in writing on or before the date a prepayment review is started. Missing from the documentation was items A through F of the requirement. The MCO has submitted a Prepayment Policy to DMS, which was not approved due to lack of information on how the process would be operationalized. The MCO is revising the policy and will resubmit for approval. **Recommendation for MCO** The MCO should submit its revised policy to DMS and begin implementation as soon as applicable.	Passport Health Plan has acted upon IPRO's recommendation. A revised Prepayment Policy was submitted to DMS on 01/22/2019. Additional meetings will be scheduled surrounding next steps for implementation once DMS approval is received.
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.		Minimal	This requirement is partially addressed in the Desktop Procedure. The procedure contains the 45 day requirement in its entirety. Missing from the documentation is reference to Contract Provision 28.9. The MCO has submitted a Prepayment Policy to DMS, which was not approved due to lack of information on how the process would be operationalized. The MCO is revising the policy and will resubmit for approval. **Recommendation for MCO** The MCO should submit its revised policy to DMS and begin implementation as soon as	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. A revised Prepayment Policy was submitted to DMS on 01/22/2019. Additional meetings will be scheduled surrounding next steps for implementation once DMS approval is received.

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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**
			applicable.	
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 each written request for such information:	Full-Includes review of individual disclosures The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.		Includes review of individual disclosures.	
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 The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.		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 The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.		Includes review of individual disclosures.	
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 The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.		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**
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 The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.		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 The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.		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	Full-Includes review of individual disclosures The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.			
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.	Full-Includes review of individual disclosures The requirement is addressed in MCO document CO 10 Ownership & Financial Disclosure.			
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				

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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**
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1 and 2, and in Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 3.			
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1 and 2, and in Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 1 and 2. New Requirement	Full	This requirement is addressed in the Compliance Program on page 2 and in the Program Integrity Plan on page 2.	
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1 and 2, and in Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 1 and 2. New Requirement	Full	This requirement is addressed in the Program Integrity Plan on page 2.	
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 1 and 2, and in Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 3.			
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 impact include cases involving:	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 5.			

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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**
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 5.			
(2) High dollar amount of potential overpayment; or	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 5.			
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 5.			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full - The requirement is addressed in documents 2016 Program Integrity Plan – see Fraud, Waste and Abuse Training, page 7; Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 8 and 9. Copies of employee certificates of completion of Fraud, Waste and Abuse training were also provided.			
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.	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 7 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 8 and 9. The MCO submitted copies of the two emails regarding attending the Health Care Fraud Task Force Conference on 9/14/16. The MCO submitted a copy of a document titled "Compliance Talk Fraud, Waste and			

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 With the Office of the Attorney General dated 10/6/16 and a copy of the presentation titled "Overview of the Medicaid Fraud and Abuse Control Unit (MFCU). At the onsite audit, staff provided evidence of training, training documents, and sample staff Continuing Learning Education (CLE) records to show compliance with the listed requirement.			
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	Non-Compliance	The MCO employs two full-time investigators. These investigators do not currently meet the experience requirement.	**Passport's Response** Passport Health Plan lost one of its full time investigators in October and DMS was notified within the required timeframe. Passport is in the process of interviewing and hiring an applicant for the vacant position. Passport has had discussions with DMS Program Integrity surrounding the staffing challenges.
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.	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 2 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 4.			

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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**
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 2 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 4.			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 4.			
D. Initiate appropriate administrative actions to collect overpayments;	Full -The requirement is addressed in documents 2016 Program Integrity Plan on page 6 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 4.			
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 Department's permission to collect overpayments in excess of $500 as an administrative recoupment or for investigation or case closure;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 2 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5. New Requirement	Full	This requirement is addressed in the Desktop Procedure on page 4.	
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 3 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 4.			
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 3 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5.			

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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**
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5.			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5.			
J. Be subject to on-site reviews and fully comply with requests from the Department to supply documentation and records;	Full -The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 8.			
K. Collect outstanding debt owed to the Department from members or providers; and provide monthly reports of activity and collections to the Department;	Full-The requirement is addressed in documents 2016 Program Integrity Plan – see Accounts Receivable, page 7 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9. The MCO provided monthly Report #71 Provider Accounts Receivable Report for the period of January 2016 through October 2016 which meets the requirement. The MCO provided monthly Report #72 Member Accounts Receivable Report for the period of January 2016 through October 2016 which meets the requirement.		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	Full - The requirement is addressed in documents 2016 Program Integrity Plan on			

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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**
appropriate action to collect the overpayment after 180 days;	page 7 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9.			
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	Full	This requirement is addressed in the Provider Levy, Garnishment, Escrow and Payment Suspension Policy.	
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9.			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9.			
P. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9.			
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;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 5 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 6.			
R. Designate a contact person to work with staff investigators and attorneys from the Department OIG and any other agent or contractor of the	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of	Full	This requirement is addressed in the Desktop Procedure on page 4.	

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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**
Department;	Fraud/Waste/Abuse on page 5. New Requirement			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 5.			
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;	Full - Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB) The requirement is addressed in documents 2016 Program Integrity Plan on page 7 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9. The MCO provided monthly Report #73 Explanation of Member Benefits for the period of January 2016 through October 2016 which meets the requirement.		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;	Full - Includes review of MCO Report #75 SUR Algorithms The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 4. The MCO provided monthly Report #75 SUR Algorithms for the period of January 2016 through October 2016 which meets the requirement.		Includes review of MCO Report #75 SUR Algorithms.	

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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**
V. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Full - The requirement is addressed in documents Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9 and Policy PI.2.00.E MPV Letters and Voluntary Restitution.			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 3. New Requirement	Full	This requirement is addressed in the Program Integrity Plan on page 2.	
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 10.			
Y. Recover overpayments from providers;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9.			
Z. Identify Providers for pre-payment review as a result of the Provider's activities in accordance with the contract;	Full - The requirement is addressed in documents 2016 Program Integrity Plan on page 4 and Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse on page 9. New Requirement	Minimal	This requirement is partially addressed in the Desktop Procedure. The MCO has submitted a Prepayment Policy to DMS, which was not approved due to lack of information on how the process would be operationalized. The MCO is revising the policy and resubmitting for approval. **Recommendation for MCO**	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. A revised Prepayment Policy was submitted to DMS on 01/22/2019. Additional meetings will be scheduled surrounding next steps for implementation once DMS approval is received.

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**
			The MCO should submit its revised policy to DMS and begin implementation as soon as applicable.	
AA. Conduct a minimum of three (3) on-site visits per 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;	New Requirement	Full	This requirement is addressed in the Provider On-Site Audits Policy.	
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	Full	This requirement is addressed in the Provider On-Site Audits Policy.	
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.	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 8.			
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.	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 8. New Requirement	Full	This requirement is addressed in the Desktop Procedure on page 8.	

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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			
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;	Full -The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			
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 administrative action;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			

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**
F. If in the process of conducting a 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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			
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 Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be	Full -The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			

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**
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:	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse on page 5, 6 and 7.			
(1) Name and address of subject,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #1, page 6. Program Integrity File Review All 10 Files met full compliance for this requirement		Includes program integrity file review results.	
(2) Medicaid identification number,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #2, page 6. Program Integrity File Review 5 out of 10 files met full compliance for this requirement. The other 5 were not applicable.		Includes program integrity file review results.	
(3) Source of complaint,	Full - Includes Program Integrity file review results		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**
	The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #3, page 6. Program Integrity File Review 10 out of 10 files met full compliance for this requirement.			
(4) State the complaint/allegation,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #4, page 6. Program Integrity File Review All 10 Files met full compliance for this requirement		Includes program integrity file review results.	
(5) Date assigned to the investigator,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #5, page 6. Program Integrity File Review All 10 Files met full compliance for this requirement		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**
(6) Name of investigator,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #6, page 6. Program Integrity File Review All 10 Files met full compliance for this requirement		Includes program integrity file review results.	
(7) Date of completion,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #7, page 6. Program Integrity File Review All 10 Files met full compliance for this requirement		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 Desktop Procedure. **Program Integrity File Review Results** Ten (10) of 10 files met this requirement.	
(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.	

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 the Desktop Procedure. **Program Integrity File Review Results** Ten (10) of 10 files met this requirement.	
(10) The issues identified;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Desktop Procedure. **Program Integrity File Review Results** Ten (10) of 10 files met this requirement.	
(11) Methodology used during investigation,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #8, page 6. Program Integrity File Review 7 out of 10 Files met full compliance for this requirement. 3 files were not applicable for this requirement.		Includes program integrity file review results.	
(12) Facts discovered by the investigation as well as the full case report and supporting documentation,	**Full - Includes Program Integrity file review results** **The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #9, page 6.**		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**
	Program Integrity File Review **All 10 Files met full compliance for this requirement**			
(13) Attach all exhibits or supporting documentation,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #10, page 7. Program Integrity File Review All 10 Files met full compliance for this requirement		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 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #11, page 7. Program Integrity File Review 6 out of 10 files met full compliance for this requirement. The other 4 files were not applicable for this requirement.		Includes program integrity file review results.	
(15) Identify overpayment, if any, and recommendation concerning collection,	Full - Includes Program Integrity file review results The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and		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 of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department, #12, page 7. Program Integrity File Review 3 out of 10 files met full compliance for this requirement. The other 7 files were not applicable for this requirement.			
(16) Reason for closure of the report, if applicable;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Desktop Procedure. **Program Integrity File Review Results** Ten (10) of 10 files met this requirement.	
(17) Request to send as a referral for a preliminary investigation for a credible allegation of fraud, if applicable; and	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the Desktop Procedure. **Program Integrity File Review Results** Ten (10) of 10 files met this requirement.	
(18) Any other elements identified by CMS for fraud referral;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Submission of Investigative Report to Department #13, page 7.			
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	Full - Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report The requirement is addressed in document		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse 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**
available to the Department upon request;	Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.			
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	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Follow-Up Reporting, page 7.			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full - The requirement is addressed in documents Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/Abuse – see Grievance and Appeal Process for members and providers, page 8; Member Handbook "If You Have a Grievance or Wish to File an Appeal", pages 37-41; and Provider Manual, Member Grievances and Appeals section 2.11 and Provider Appeals and Grievance section 2.9.			
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	Full	This requirement is addressed in the Desktop Procedure on page 7.	

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.				
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	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Associate/Subcontractor Reporting, page 7-8.	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in reports #76 and #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**
have the ability to report all aspects of a member or provider file from opening to closure) to the Department upon request, including overpayments identified, overpayment adjusted and recoupments of overpayments;	The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement. New Requirement			
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	Full	This requirement is addressed in the Desktop Procedure.	
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	Full	This requirement is addressed in the Desktop Procedure.	
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	This requirement is addressed in the Desktop Procedure.	
E. The Contractor shall report all overpayments identified as prescribed by the Department;	New Requirement	Full	This requirement is addressed in the Desktop Procedure.	
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 is addressed in the Desktop Procedure.	
G. The Contractor shall report the escrow of provider payments in adherence to state requirements;	New Requirement	Full	This requirement is addressed in the Desktop Procedure.	

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**
H. The Contractor shall report site visits conducted in adherence to state requirements; and	New Requirement	Full	This requirement is addressed in the Desktop Procedure.	
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:			Includes review of MCO Report #76 and Report #77.	
(1) PIU Case number;	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.		Includes review of MCO Report #76 and Report #77.	
(2) Provider /Member name;	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.		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**
(3) Provider Medicaid ID /Member Medicaid number;	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.		Includes review of MCO Report #76 and Report #77.	
(4) Date complaint received by Contractor;	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.		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 the Desktop Procedure and in Report #76.	

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**
(6) Source of complaint	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.		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 the Desktop Procedure and in Report #76.	
(8) Date complaint or referral received	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in Report #76 and Report #77.	
(9) Date opened	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76		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**
	Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the 1st, 2nd and 3rd quarters of 2016 which meet the requirement.			
(10) MAT related (Y or N);	New Requirement	~~Minimal~~ Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure; however, it is missing from the reports submitted by the MCO. **Recommendation for MCO** The MCO should add MAT language to its reports. **Final Review Determination** Based on PHPs response and review of reports after January 1, 2018 it was determined that this field was in report 76.	**Passport's Response** DMS dictates the format for this report, and Passport utilizes the template supplied by DMS. DMS emailed all of the MCOs on October 19, 2017 updating reporting requirements for the quarterly report 76. These updates included adding columns to address provider prepayment (Y or N) and MAT cases (Y or N) effective January 2018. All submissions of report #76 after January 2018 included these columns.
(11) Summary of complaint with timeframe reviewed;	Full - Includes review of MCO Report #76 and Report #77 The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Reporting, #1, page 7. The MCO provided quarterly Report #76 Provide Fraud Waste Abuse Report and Report #77 Member Fraud Waste Abuse Report. Both reports submitted were for the		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**
	1st, 2nd and 3rd quarters of 2016 which meet the requirement.			
(12) Initial investigation (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in Report #77.	
(13) Actions taken;	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in reports #76 and #77.	
(14) Referred to DMS (with appropriate code);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in reports #76 and #77.	
(15) Date referred to DMS (if applicable)	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in reports #76 and #77.	
(16) Provider on prepayment (Y or N);	New Requirement	~~Minimal~~Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure; however, it is missing from the reports submitted by the MCO. **Recommendation for MCO** The MCO should add "Provider on prepayment" to its reports.	**Passport's Response** DMS dictates the format for this report, and Passport utilizes the template supplied by DMS. DMS emailed all of the MCOs on October 19, 2017 updating reporting requirements for the quarterly report 76. These updates included adding columns to address provider prepayment (Y or N) and MAT cases (Y or N) effective January 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**
			Final Review Determination Based on PHPs response and review of reports after January 1, 2018 it was determined that this field was in report 76.	All submissions of report #76 after January 2018 included these columns.
(17) Overpayment identified, and	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and in reports #76 and #77.	
(18) Date case closed (if applicable).	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is addressed in the Desktop Procedure and 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;	Full - This requirement is addressed in the desktop policy and procedure document for UHC-CO-08 Program integrity Desktop Procedure for Prevention/Detection and Investigation of Fraud/Waste and Abuse			
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;	Full - This item is addressed by the MCO's Encounter data submission policy.			
C. Backup, store or be able to recreate reported	Full - This item is addressed by the two			

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**
data upon demand for the Department the OIG and any other agent or contractor of the Department;	policies on record retention and electronic backup and recovery. The Encounter Acceptance Rate Report procedure is proof that the MCO has standardized processes in place to recreate reports as needed.			
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;	Full-The item is addressed on page 3 of the Desktop Procedure for Program Integrity-Prevention, Detection and Investigation of Fraud/Waste/Abuse			
E. Produce records in electronic format for review and manipulation by the Department the OIG and any other agent or contractor of the Department;	Full - The item is addressed by the Encounter Data Submission process.			
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;	Full - This item is addressed by the Program Integrity Plan document on page 8.			
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;	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Procedure – Program Integrity Unit, page 3.			
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	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Department Requests and Cooperation with the Office of Inspector General (OIG) and United States Attorney's			

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**
	Office, page 8.			
I. Provide identity and cover documents and information for law enforcement investigators under cover.	Full - The requirement is addressed in document Policy PI.1.00.e Prevention, Detection and Investigation of Fraud/Waste/ Abuse – see Department Requests and Cooperation with the Office of Inspector General (OIG) and United States Attorney's Office, page 8.			

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MCO: Passport Health Plan

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	64	0	6	2
Total Points	192	0	6	0

Overall Compliance Determination:

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

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

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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.	Full - Includes review of MCO Report #93 EPSDT CMS-416 and MCO Report #24 The 2016 EPSDT Program Description, the Member Handbook and the Provider Manual indicate that members under the age of 21 are automatically eligible for the EPSDT program. Members may opt out of the outreach component and still remain eligible for the services (page 6 of the Scope of Services Policy). Recommended screenings and components of age-appropriate screenings are documented in the Provider Manual. The plan submitted Form 416 reports as evidence of quarterly and annual submission of EPSDT screening and participation rates. The plan reported an EPSDT screening rate of 78% for 2015. The participation rate was 63% which was below the goal of		Includes review of MCO Report #93 EPSDT CMS-416 and MCO Report #24.	

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**
	80%.			
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Full - The EPSDT Scope of Services Policy and the Provider Manual state that PCPs that care for children under 21 years of age are required to perform EPSDT services. EPSDT services are also performed by the Department of Health. The Provider Manual, EPSDT Orientation Packet, New Provider Toolkit, website, and face-to-face office visits provide targeted education on the EPSDT program to the plan's providers.			
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034, and who are supported by adequately equipped offices to perform EPSDT services.	Full - The Provider Manual, EPSDT Orientation Packet, New Provider Toolkit, website, and face-to-face office visits provide targeted education on the EPSDT program to the plan's providers. The Provider Manual outlines provider responsibility with regards to access and availability for EPSDT services, standards for appointment scheduling and after hours coverage.			

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**
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.	Full - This requirement is addressed in the Member Handbook, Member Confirmation Letter, Member Newsletter, Soundcare message, the plan's website, quarterly mailings, telephonic outreach, distribution of materials at community events and onsite visits are documented activities in the work plan reports.			
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.	Full - Includes file review results for EPSDT UM files and EPSDT Appeal files This requirement is addressed in the Member Handbook which informs members and their families about the EPSDT Program, their rights, and how to access services. Information about the right to appeal and how to contact member services is included in the Member Handbook and in the Member Newsletter. UM and Appeals EPSDT File Review Results 2 of the 5 UM EPSDT files reviewed were administrative		Includes file review results for EPSDT utilization management (UM) files and EPSDT appeal files.	

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**
	denials and 3 were medical denials. For the 3 UM EPSDT medical denials, all letters contained language addressing member's right to appeal. 5 out of 5 Member Appeals EPSDT files also showed letters addressing member's right to appeal. For 4 of the 5 Member EPSDT Appeals, where the MCO overturned the initial decision, the language of the member's right to a state hearing if a denial is upheld, their right to receive benefits while hearing is pending, and member's liability for costs is discussed in the MCO's appeal acknowledgement letter and not in the resolution letter. Only 1 of the 5 EPSDT appeal files showed an appeal was upheld. The resolution letter for the one member did contain language on the state hearing and the member's right to receive benefits, but the language addressing the member's liability for costs if state hearings uphold the appeal decision is not mentioned. However, the acknowledgement letter to the member did contain all required			

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**
	information.			
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.	Full - The 2016 EPSDT Program Description and Scope of Services address the requirement that the plan provide EPSDT services to all eligible members in accordance with regulatory guidelines. The EPSDT periodicity schedule is found on page 6 of the Provider Manual and on page 45 of the Member Handbook. The 2016 EPSDT audit provider sample was identified utilizing the following criteria: •Participating (PAR) providers: O with a claims count of 50 or more during CY 2015 O Who billed EPSDT CPT codes in Region 3 utilizing the EP modifier during the OR O Who billed EPSDT CPT codes outside of Region 3 without the EP modifier during the MY of 2015 • 97 providers were identified outside of Region 3 including: O 5 providers in Region 1 O 14 providers in Region 2 O 13 providers in Region 4 O 33 providers in Region 5			

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**
	O 3 providers in Region 6 O 12 providers in Region 7 O 17 providers in Region 8 • 132 providers were identified in Region 3, however, a total of 60 were reviewed and achieved a score of 80% or above during the 2015 audit and will not be re-reviewed during 2016 leaving a total of 72 to be reviewed during 2016. The MCO provided a 2016 EPSDT Provider Compliance and Claims Audit Summary and analysis indicates that the MCO took into account Claims audits were conducted for all regions, and were categorized into 'Region 3' (97 reviews) and 'Outside Region 3' (52 reviews). At the onsite, staff explained the bulk of the network providers reside in Region 3. The summary findings indicate that in-depth analysis for 'Outside Region 3' areas can be found in the 2016 EPSDT Program Evaluation.			
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary	Full - The 2016 EPSDT Program Description and EPSDT Scope of			

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**
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.	Services 2016 provide evidence that the providers within the network provide all needed initial, periodic and inter-periodic health assessments in accordance with the Kentucky Administrative Register. EPSDT Provider Compliance and Claims Audits summary document provided on site and staff explanations indicated that audits were performed for all regions.			
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.	Full - This requirement is addressed in the 2016 Scope of Services. Additionally, the Provider Manual describes EPSDT Expanded Services as those required to treat conditions detected during an encounter with a healthcare professional and are eligible for payment under the federal Medicaid program but not currently recognized under the state plan. Providers must submit requests to the UM department for determination of medical necessity and authorizations.			
F. Provide EPSDT Special Services for eligible members,	Full - The Provider Manual and			

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**
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.	the 2016 Scope of Services address this requirement.			
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.	Full - This requirement is addressed in the 2016 Scope of Services which indicates that reports are generated by the EPSDT department based on claims data to track the number of comprehensive screens reported. The plan provided a screenshot of the EPSDT Call Center application that tracks screens due for each member, the last screen conducts, and the outreach conducted and includes the date and time of appointment.			
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,	Full - This requirement is addressed in the 2016 Scope of Services which describes the frequency and type of outreach attempts and cites the Identification and Outreaching of Members for Case Management Services Policy. This policy outlines care coordination			

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**
and follow up with eligible Members and their families when recommended assessments and treatment are not received.	procedures and assists members in obtaining needed services.			
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.	Full - This requirement is addressed in the 2016 Scope of Services which indicates that reports are generated by the EPSDT department based on claims data to track the number of comprehensive screens reported. The plan provided a screenshot of the Call Center which has an application that tracks screens due for each member, the last screen of the member, results of outreach calls, and the date and time of all appointments.			
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.	Full - The Provider Manual includes the processes for clinical coordination between behavioral health providers and PCPs including the requirement that behavioral health providers communicate with PCPs if the members consent. The 2016 EPSDT Program Description provides the process the plan uses to assess its objectives, activities and outcomes, including care			

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**
	coordination. This is accomplished through an annual evaluation.			
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.	Full - This requirement is addressed in the Desktop Procedure for EPSDT Special Services. This ensures that the plan provide any medically necessary services to a child, even if the service is not available under the State's Medicaid plan to adults.			
K. Participate in any state or federally required chart audit or quality assurance study.	Full - This requirement is addressed in the QI Program description. Additionally, the plan submits 416 quarterly reports and analyzes the results. The plan also participated in a review of EPSDT services that was conducted by the EQRO on behalf of the State by providing requested medical records for review.			
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	Full - This requirement is addressed in the EPSDT QI Education Manual. The plan provided the attendance sheets for providers that attended EPSDT trainings in 2016.			

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**
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.				
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.	Full - The plan submits CMS Form 416 quarterly and evaluates the results. The plan provided these quarterly reports for the review period. Report 38 was submitted as evidence of EPSDT encounter records. This report lists provider types, billing codes, and modifiers used, number of members and the dollar amount paid or denied.			
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Full - A job description was submitted for Program Coordinator in the Care Coordination Department. This position is responsible the monitoring of goals related to EPSDT activities, overseeing the tracking system, educating members and providers regarding age-appropriate screenings, and implementation of all aspects of the EPSDT outreach program.			
9.2 Administration/Staffing	New Section Heading			

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**
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. 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.	New Requirement	Full	This requirement is addressed in the job description of the program coordinator for pediatric services and the resume of the coordinator.	
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 addressed in the 2016 Scope of Services.			
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.	Full - Includes review of MCO Report #93 EPSDT CMS-416 As per Report 38, the plan submits encounter records for EPSDT services including the use of EPSDT procedure codes. Encounter data with appropriate codes and EP modifiers were provided. The plan submits quarterly and annual EPSDT services on form 416.		Includes review of MCO Report #93 EPSDT CMS-416.	

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Final Findings

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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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**
4.3 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	Full		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 in the template agreement provided by the MCO. All 11 of the MCO's subcontractor agreements contained this requirement.	
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 in the template agreement provided by the MCO. All 11 of the MCO's subcontractor agreements contained this requirement.	

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	Full	Includes review results for each subcontractor. This requirement is addressed in the Delegated Entity Oversight Policy and in the subcontractor agreements. All 11 of the MCO's subcontractor agreements contained this requirement.	
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.	**Passport's Response** Passport Health Plan acknowledges receipt of IPRO's recommendation. Passport will review our subcontractor agreements and address this new requirement.
6. provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate	Full		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.	Full - Includes review results for each subcontractor This requirement is addressed in the Delegation Oversight Manual as well as the Subcontractor Oversight Policy and Procedure. Evidence of pre-delegation audits was provided for all entities contracted with during the review period: ACS/Xerox, Beacon Health Services and Optum.		Includes review results for each subcontractor.	
C. The Contractor shall monitor the Subcontractor's	Full - Includes review results for each		Includes review results for each	

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**
performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	subcontractor This requirement is addressed in the Delegation Oversight Manual and the Subcontractor Oversight Policy and Procedure. The requirement is communicated to the subcontractors in the Subcontractor Agreements. PHP monitors each delegated entity at least quarterly and performs an annual formal audit of each delegation. Annual Audit dates and results: Each vendor was audited during the review period as shown with documentation provided by Passport. AmeriHealth Caritas Health Plan - 7/2016 Aperture Credentialing, LLC (assigned by OptumInsight, Inc.)-6/2016 Avesis Third Party Administrators, Inc.-11/2016 Falcon Subsidiary, LLC dba AxisPoint Health (assigned by McKesson Health Solutions, LLC)-8/2016 Beacon Health Strategies, LLC-1/2016 eviCore Healthcare		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**
	(formerly MedSolutions, Inc.)- 4/2016 OptumInsight, Inc.-3/2016 Superior Vision Benefit Management, Inc. (formerly Block Vision, Inc.)-2/2016 Xerox Recovery Services, Inc. (formerly ACS Recovery Services, Inc.)-6/2016 CVS Pharmacy-8/2016 Evolent Health, LLC-2/2016 & 7/2016			
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Full - Includes review results for each subcontractor This requirement is addressed in the Delegation Oversight Manual. This requirement is communicated to the subcontractor through the pre-delegation summary report and also through the subcontractor agreement. This requirement is implemented through the ongoing monitoring of each subcontractor and through the annual audit.		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.	Full - Includes review results for each subcontractor This requirement is addressed in the Delegation Oversight Manual.		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**
	This requirement is communicated to the subcontractor through the subcontractor Agreement.			
F. The Contractor shall assure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable subregulatory guidance and contract provisions.	Full - This requirement is addressed in subcontractor agreement. This requirement is communicated to the subcontractors through the subcontractor agreement.			
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.	Full - Includes review results for each subcontractor PHP provided evidence of a current agreement with each of its delegates whereby each Agreement provided that the subcontractor shall indemnify, defend and hold harmless the Commonwealth, its officers, agents and employees and each and every member from any liability arising in connection with its Contract for the payment of any debt or the fulfillment of any obligation of the subcontractor.		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	Full - Includes review results for each subcontractor This requirement is addressed in the subcontractor agreement.		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**
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.	This requirement is communicated to the subcontractor through the subcontractor agreement.			
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member, 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,	Full - List subcontractors contracted with the MCO and type of services provided AmeriHealth Caritas Health Plan-TPA Aperture Credentialing, LLC-CVO (assigned by OptumInsight, Inc.) Avesis Third Party Administrators, Inc.-Dental Falcon Subsidiary, LLC dba AxisPoint Health (assigned by McKesson Health Solutions, LLC)-24 Hr Nurse Line Beacon Health Strategies, LLC-Behavioral Health eviCore Healthcare-Radiology (formerly MedSolutions, Inc.) OptumInsight, Inc.-FWA Superior Vision Benefit Management, Inc. (formerly Block Vision, Inc.)-Vision			

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**
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.	Xerox Recovery Services, Inc.-Subrogation (formerly ACS Recovery Services, Inc.) CVS Pharmacy-PBM Evolent Health, LLC-MCOE Alliance Magellan (PBM) terminated 8/31/2016 The Delegation Policy addresses the requirement that all amendments to the subcontractor agreement be in writing and approved by DMS as seen in Section 2.2.3.			
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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		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**
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		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**
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 addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
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 addressed in subcontractor agreement and amendment documentation.		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 addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
(2) all QAPI requirements,	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
(3) all record keeping and reporting requirements,	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		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 addressed in 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**
	agreement and amendment documentation.			
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
(6) all indemnification and insurance requirements, and	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
(7) all obligations upon termination;	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		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 to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;	Full - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		Includes review results for each subcontractor.	
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 - Includes review results for each subcontractor This requirement is addressed in subcontractor agreement and amendment documentation.		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**
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 subcontractor agreement and amendment documentation.		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 subcontractor agreement and amendment documentation.		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 subcontractor agreement and amendment documentation.		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 to Members.	Full - This requirement is communicated to the subcontractors through the subcontractor agreement. Quarterly delegate newsletters serve to remind the subcontractors of contractual responsibilities.			
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.	Full - This requirement is communicated to the subcontractors through the subcontractor agreement. Quarterly delegate newsletters serve to remind the subcontractors of contractual responsibilities.			

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	3	0	0	1
Total Points	9	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		**2.25**		

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

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 requirement is addressed by Encounter Acceptance Rate Report SOP. The Acceptance Rate By Sub-Contractor reports provide proof that files are submitted according to regulation standards and that the plan is able to track and summarize rejected encounters back to subcontractors. This requirement is also addressed by the KY Encounter Process Documentation.			
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter identification number for each Encounter.	Full-This requirement is addressed by the KY Encounter Process Documentation.			
At a minimum, the Contractor shall be required to electronically provide Encounter Files to the Department, on a weekly schedule.	Full-This requirement is addressed by Encounter Acceptance Rate Report SOP. Encounters are submitted to DMS between Monday and Passport's Sunday submission day. This requirement is also addressed by the KY Encounter Process Documentation.			

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**
Encounter Files must follow the format, data elements and method of transmission specified by the Department.	Full-This requirement is addressed by the KY Encounter Process Documentation.			
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-Encounter data files are regularly submitted to DMS in standard file formats.			
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 Passport Policy-Encounter Acceptance Rate report document shows subcontractor file acceptance rates. This requirement is also addressed by the KY Encounter Process Documentation under the 'Adjustment Process' and 'Error Correction Process' sections.			

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**
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting 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.	Full-This requirement is met by the KY Encounter Process Document. Also addressed within the process document, subcontractors (Beacon, Avesis, CVS, Magellan, and Superior) submit their encounter data to Amerihealth Caritas for file checking and internal compliance checks prior to submission to DMS.			
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-Addressed in Third Party Services Agreement with vendors. Wording seen on Amerihealth's 2014 agreement with Passport on page 41, Aperture's agreement on page 23, Avesis and Beacon agreements on page 3 and Magellan on page 11.			
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-Staff provided an email screenshot to DMS at the onsite audit that shows evidence of EDI contacts			
16.2 Technical Workgroup				
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled	Full-The document '20160317 MCO Technical Workgroup			

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**
by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter submission.	Meeting Minutes' shows evidence of Passport's participation in the Encounter Technical Workgroup			
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.	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 in the provider manual on page 59, wherein the MCO's encouragement of providers to connect to the KHIE is stated. The MCO has an orientation policy (PR 58.0) which references the New Provider Orientation Kit, but neither the policy nor the orientation kit specifies notification regarding Participation Agreement. **Recommendation for MCO** The MCO should establish a standard wherein newly contracted providers are encouraged to sign a Participation Agreement with KHIE within one month of when the recommendation was made to join the exchange. Further, if possible, the MCO should track the execution of these agreements, to see where gaps exist and/or opportunities remain.	

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**
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 is minimally addressed in the provider manual on page 59, wherein hospitals are referenced as part of the participating group of providers that share information via the KHIE. Specific reference to how they should submit admission, discharge, transfer messages (ADTs) via this exchange is not referenced. The Site Visit Form references KHIE education as a whole; however, it does not specify ADTs. **Recommendation for MCO** The MCO should include a reference within the provider manual for hospitals specifically, which specifies the recommendation that these facilities submit ADTs via the KHIE. Further, MCO staff should ensure they communicate this functionality, when performing site visits at hospitals (and during the new provider orientation process, if a hospital is newly contracted).	
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 is minimally addressed in the	

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**
			provider manual on page 59, wherein the MCO's encouragement of providers to connect to the KHIE is stated. There is no specific reference to the Participation Agreement or Direct Secure Messaging services. The MCO's Site Visit Form has a section for KHIE education as a whole; however, the Participation Agreement and Direct Secure Messaging Services are not specified, nor was staff training documented that evidenced that these facets were communicated to providers. **Recommendation for MCO** The MCO should include within the provider manual a reference to the Participation Agreement and the Direct Secure Messaging service. Further, MCO staff training on the Site Visit Form should ensure that communication regarding these facets is part of the standard training to providers.	
30.2 Prompt Payment of Claims				
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-Page 1 of the document 'Claims Adjudication and Processing' states that Amerihealth Caritas Health Plan (ACHP) requires a service level standard of adjudicating 99% of all claims within 90 days of receipt. The report titled '2016-1118	Full	This requirement is addressed on page 2 of the Claims Adjudication Process Policy. The MCO submitted claims payment activity reports, which demonstrate the number of claims paid/denied/suspended within 30 days, 60 days, 90 days, and 91+ days. These reports provide evidence of 99% of all claims being processed within 90 days of receipt.	

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**
	Weekly Scorecard_1300' lists Passport's timeliness of claims payments for two months of the year and shows evidence of adherence to the listed requirement. The timeliness of claims payments policy was provided to support this requirement as well. New Requirement			
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended. 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 item is addressed in the 'Claims Adjudication and Pricing' document.			
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 the 2018 Passport Utilization Management Program Description on page 35, which states, "If Passport issues a final decision which denies, in whole or in part, a health care service or claim for reimbursement, we notify the provider in writing of their right to an external third-party review." Execution of this requirement is evidenced	

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**
			within CP-13111 (the provider medical appeal upheld template letter).	

Final Findings

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health 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**
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				

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**
who also require health and related services of a type or 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.	Full - This requirement is addressed in the CM Care Plan Development on pages 3 and 4 and the 2016 Complex Case Management Program Description document.			
Members needing Care Management Services shall be identified through the health risk assessment, evaluation	Full - Includes review of MCO Report #79 HRAs (see Quarterly		Includes review of MCO Report #79 Health Risk Assessments (HRAs; see Quarterly	

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**
of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.	Desk Audit results) This requirement is addressed in the MCO Report 79 and the CC 4 05 Identification and Outreaching of Members for Case Management Services document.		Desk Audit results).	
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.	Full - This requirement is addressed in the Confidentiality Privacy and Disclosure Guidelines for Care Coordination document and the Clinical Practice Guidelines document.			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Full - This requirement is addressed in the PHP Policy BH 10.0 Identification of DCBS Clients for Behavioral Health-Care Coordination Services.			
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.	Full - This requirement is addressed in the 2016 Complex Case Management Program Description document on page 7.			
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.				

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 identify the primary elements for care coordination and submit the plan to the Department for approval.	Full - This requirement is addressed in the PHP - CC - 4 06 Care Coordination Processes Scope of Services document.			
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 with the Primary Care Provider's clinical treatment plan and medical diagnosis.	Full - This requirement is addressed in the CC 24 01 Case Management for Members Followed by Commission for Children Special Health Care Needs, Version 4 document and the CC 4 05 Identification and Outreaching of Members for Case Management Services document.			
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full - Includes review results for Care Coordination and Complex Case Management files This requirement is addressed in the PHP - CC - 4 06 Care Coordination Processes Scope of Services document on page 1 and the 2016 Complex Case Management Program Description on page 6. Care Coordination and Complex Case Management file review		Includes review results for care coordination and complex case management 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**
	For the Care Coordination files, 9 out of 10 files reviewed showed a comprehensive assessment, and showed evidence of identification of physical and behavioral health needs of the member. The MCO's explanation for the 1 member out of 10 who did not have a clear assessment was the MCO was not informed of the patient's delivery until after the patient delivered. File review showed there were multiple phone calls made to reach the member. The MCO explained if they cannot reach the member, they cannot perform an assessment. 8 of the 9 files with comprehensive assessment showed evidence of a care plan. All 9 files showed identification of physical and behavioral health needs. For the Complex Case Management files, all 10 files reviewed met compliance for having a comprehensive assessment, a care plan and identification of physical and behavioral health needs of the member.			

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 MCO provided adequate coordination of care by addressing maternity care, pediatric and a variety of illnesses/ conditions. The MCO continues to make strides by accommodating the needs of the member(s) in a timely and efficient manner. Case managers and care coordinators screened enrollees to address any special health care needs and conducted activities to accomplish these tasks. Tasks and barriers are tracked and followed up by documentation of communication made by the case manager or MCO specialist to accomplish every goal/barrier intervention(s). <u>Passport's Response</u> Passport Health Plan does address alternate methods of outreach to complete the care coordination assessment. Passport's Care Coordination policies require staff to outreach to members using various methods. Policy CM.002.E Outreach and Engagement			

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**
	specifically states: Members are outreached by using various methods, which may include sending a Care Management Introduction letter, which includes information about the program and the Care Advisor's contact information. If initial outreach to member is unsuccessful, Care Advisors will make two additional outreach calls over 2 weeks at different times of the day and on different days. Care coordination staff will explore multiple avenues to find working phone numbers for members, including but not limited to web tools, contacting physician offices and pharmacies. Passport's Quality Auditing process and tool reviews for compliance with these outreach procedures, including the use of various methods to reach members. Final Review Determination Based on PHP's response the final			

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**
	determination was changed to Full.			
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Full - Includes review results for Care Coordination and Complex Case Management files This requirement is addressed in the 2016 Complex Case Management Program Description document. Care Coordination and Complex Case Management File Review: 9 out of 10 Care Coordination files had a comprehensive assessment, and 8 of those 9 files showed a care plan. 10 out of 10 Complex Case Management files had evidence of a comprehensive assessment and a care plan. Recommendation for Passport Passport should examine ways to ensure that all care coordination files contain a care plan. Passport's Response:	Full	Includes review results for care coordination and complex case management files. This requirement is addressed in the 2017 Complex and Conditions Care Program Description. **Care Coordination File Review Results** Ten (10) of 10 care coordination files had a comprehensive assessment and care plan. **Complex Case Management File Review** Not applicable; complex case management file review deemed for the 2018 compliance review.	

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**
	Passport Health Plan has acted upon IPRO's recommendation by ensuring that all care coordination files contain a care plan. Passport's Care Coordination policies require staff to outreach to members using various methods. CM.007.E CM Care Plan Development and Monitoring, that was provided prior to the onsite, requires that every member engaged into a case management/care coordination program have an individualized care plan developed and in place. The care plan addresses the member's immediate and ongoing needs, as well as identifies appropriate and necessary care management and self-management strategies and goals to address those needs. The case reviewed where a care plan did not exist should not have been included in the sample because the member was never reached (after multiple methods and attempts) to enroll in the program. Since the member was not enrolled in the program,			

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**
	there was not a care plan in place. This was explained to the auditors during the review. Final Review Determination No change in determination. 1 of 10 files was missing an assessment and 2 of 10 files were missing a care plan. Even if one of the members could not be contacted, there were 2 without a care plan.			
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.	Full - This requirement is addressed in Report 65 Foster Care Report 3rd Quarter and the FC.011.E.KY Guardianship Case Management Process final 1116 document.			
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.	Full - This requirement is addressed in the provider orientation kit document.			
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				

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**
have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.	Full - This requirement is addressed in the 2016 Complex Case Management Program Description – final document on page 4.			
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.	Full-This requirement is addressed in the2016 Complex Case Management Program Description – final document on page 4.			
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.	Full-This requirement is addressed in the2016 Complex Case Management Program Description – final document.			
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);	Full-This requirement is addressed in the 2016 Complex Case Management Program Description document and the PHP - CC - 5 04 Identification of Members with Special Health Care Needs document.			

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**
E. Individuals with chronic physical health illnesses; F. Individuals with chronic behavioral health illnesses; and G. Children receiving EPSDT Special Services.				
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.	Full-This requirement is addressed in the CC.408.P Case Management Care Coordination Clinical Library document and via the plan's website.			
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-This requirement is addressed in the 2016 Complex Case Management Program Description on page 4 and the PHP - CC - 5 04 Identification of Members with Special Health Care Needs document.			
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.	Full-This requirement is addressed in the PHP - CC - 5 04 Identification of Members with Special Health Care Needs document.			
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.	Full - This requirement is addressed in the PHP - CC - 5 04 Identification of Members with Special Health Care Needs, the provider orientation kit, and the			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	DM.001.E Clinical Practice Guidelines final 0616 document.			
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.	Deem for 2017		Includes review results for DCBS service plan and DCBS claims/case management files.	
36.3 Adult Guardianship Clients				
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 the FC.011.E.KY Guardianship Case Management Process final 1116 document.			
36.4 Children in Foster Care				
No less than quarterly, Contractor's staff shall meet with	Full - This requirement is			

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**
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 specialty care providers are enrolled in the Contractor's Network.	addressed in the FC.010.E.KY Identification of DCBS Clients for Behavioral Health and Care Coordination Services document on page 5.			
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 - Includes review results for DCBS Service Plan files This requirement is addressed in the FC.010.E.KY Identification of DCBS Clients for Behavioral Health and Care Coordination Services document. <u>DCBS file Review results:</u> All 10 sample files reviewed showed ongoing care coordination to ensure access. All files showed referral to Case Management as needed, as well as coordination with foster parents and/or DCBS staff for the development of a new case management plan. Claims or file documentation showed evidence of Physician well visits for 7 of the 10 files		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**
	reviewed; EPSDT services for 8 of the 10 files reviewed; for the 2 files without evidence of EPSDT services, there was evidence of outreach attempts.			
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 the 2016 Complex Case Management Program Description – final document. DCBS file review results: All 10 sample files reviewed showed ongoing care coordination to ensure access. All files showed referral to Case Management as needed, as well as coordination with foster parents and/or DCBS staff for the development of a new case management plan.		Includes review results for DCBS service plan files.	
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	Full - The policy on Identification of DCBS Clients for Behavioral Health/Care Coordination Services addresses the language on page 4.			

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**
discussed by the DCBS and Contractor staff will be forwarded to the designated Department representative.				
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	The MCO provided decertification emails to DMS as evidence of meeting this requirement. This requirement is also addressed in Procedure for Monitoring of Members Denied While in DCBS Custody v2, bullet 8 (note that an update to this procedure was made after the measurement period for this review, on 10/11/18).	
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 Procedure for Monitoring of Members Denied While in DCBS Custody v2. Further evidence of this requirement was demonstrated in the decertification notification emails that the MCO sent to DMS.	
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	New Requirement	Substantial	The Procedure for Monitoring of Members Denied While in DCBS Custody v2 includes the decertification process and how the MCO is notified; however, there is no specific language pertaining to failure to notify DMS or DCBS and the corresponding	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. The revised Procedure has been fully adopted and has replaced the prior version.

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**
facility prior to notification and up to three (3) business days or seven (7) business days, as applicable, after notification.			implications. On 10/11/18, the MCO provided an update for this procedure that directly references the requirement. On site, the MCO indicated that they conduct weekly internal meetings to review members that are decertified to uncover barriers and payment responsibility. **Recommendation for MCO** The MCO should substitute the revised policy for the original policy, as former fully addresses the requirement.	 Procedure for monitoring of mor
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 DCBS Custody v2, bullet 5. On site, the MCO indicated that they have a case manager embedded within a local behavioral health facility who has weekly meetings with the director of inpatient services. This ensures consistent communication and appropriate monitoring of members. Further, the MCO provided the ICM-Provider PCP Letter, Complex and Condition Care Program Description, Case Management notes, Clinical Care Coordination Procedure, and Catastrophic Care Program Description as evidence for	

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**
			meeting this requirement.	
33. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that has the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.	Full-This requirement is addressed in the RE 29 0 Child Sexual Abuse Medical Exam Reimbursement document.			
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.	Deemed 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	Deemed 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**
simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.				
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.	Deemed for 2017	Full	Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results). This requirement is addressed in Report #65 Foster Care, which details, by region, the number of new and existing foster care members, along with those enrolled in case management, disease management, and who had a completed HRA on file with the MCO. Furthermore, Report #66 Guardianship details, by region, the number of new and existing guardianship members, along with those enrolled in case management, disease management, and who had a completed HRA on file with the MCO. The MCO also submitted Foster Care Service Plan quarterly reviews for January–March 2018 and April–June 2018. The latter includes data for "program create date" and "assessment complete date," along with a notes field.	

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**
			Lastly, the MCO provided service plan examples that demonstrate Case Management needs assessments, and rationale for referral/non-referral.	

Final Findings

Case Management/Care Coordination

Scoring Grid:

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

Overall Compliance Determination:

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

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

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.	Full - This requirement is addressed in the Member Rights and Responsibilities policy (MS 21.0). A written description can be found in the Member Handbook on page 28 to 29.			
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Full - This requirement is addressed in the Member Rights and Responsibilities policy (MS 21.0). This item is fully addressed in the MCO's policy for Ensuring Out-of-Network Providers Access to Information.			
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 33.			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 33.			
C. Consent for or refusal of treatment and active participation in decision choices;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 33.			

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**
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 33.			
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 34.			
F. Timely access to care that does not have any communication or physical access barriers;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 34.			
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 34.			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 34.			
I. Timely referral and access to medically indicated specialty care; and	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 34.			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Full - This requirement is addressed in the Member Handbook on page 28. Additionally, it is stated in the Provider Manual on page 34.			
K. Any Indian enrolled with the Contractor eligible to	Full - This requirement is addressed	Full	This requirement is addressed in the member	

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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**
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.	on page 2 of the Member Rights and Responsibilities policy (MS 21.0). However, it is not included in the list of member rights in the Member Handbook, or in the Provider Manual. <u>Recommendation for Passport</u> Include this right in the list of Member Rights in the Member Handbook. <u>Passport's Response:</u> Passport Health Plan has acted upon IPRO's recommendation by including the requirement information in Passport's online Member Handbook. This information will be included via a hard copy in the 2018 Member Handbook.		handbook on page 31.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Full - This requirement is addressed on page 2 of the Member Rights and Responsibilities policy (MS 21.0), It is also addressed on page 28 of the Member Handbook.			
B. Abide by the Contractor's and Department's policies and procedures;	Full - This requirement is addressed on page 2 of the Member Rights and Responsibilities policy (MS 21.0), It is also addressed on page 28 of the			

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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**
	Member Handbook.			
C. Become informed about service and treatment options;	Full - This requirement is addressed on page 2 of the Member Rights and Responsibilities policy (MS 21.0), It is also addressed on page 28 of the Member Handbook.			
D. Actively participate in personal health and care decisions, practice healthy life styles;	Full - This requirement is addressed on page 2 of the Member Rights and Responsibilities policy (MS 21.0), It is also addressed on page 28 of the Member Handbook.			
E. Report suspected Fraud and Abuse; and	Full - This requirement is addressed on page 2 of the Member Rights and Responsibilities policy (MS 21.0), It is also addressed on page 28 of the Member Handbook.			
F. Keep appointments or call to cancel.	Full - This requirement is addressed on page 2 of the Member Rights and Responsibilities policy (MS 21.0), It is also addressed on page 28 of the Member Handbook.			
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:	New Requirement	Full	These requirements are addressed as follows: A. This requirement is addressed in the New Member Kit/Packet Generation Policy (53.0). B. This requirement is addressed by members who opt-in to receive emails from the MCO upon registration of the member portal. C. This requirement is addressed in the member handbook on pages 4 and 32, as	

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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**
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.			well as online at http://passporthealthplan.com/members/using-your-benefits/ . D. This requirement is addressed in the member handbook on pages 4 and 32.	
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 Kit/Packet Generation Policy (53.0).	
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 member handbook on page 4 with a link and instructions for obtaining the handbook via the MCO's website.	
The Member Handbook shall be available in English, Spanish and each prevalent non-English language.	Full - The plan provided the Spanish version of the Handbook. The English version was located on the MCO's website. Additionally, the MCO provided a regional analysis of	Full	This requirement is addressed by viewing the current member handbook in both Spanish and English, which is also available online. In addition, the member handbook has a section Getting Care When You Need an Interpreter or Translator. It	

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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**
	the rates of members who do not speak English as a first language, but the document (Threshold Languages 2016) does not note any specific languages. The language is addressed in the Member/Provider/Care Connectors Service Department Function on page 2. New Requirement		directs the member to call their member service number to get any material in a language of choice.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full - This includes review of online Member Handbook to confirm posting of current handbook. The MCO provided a letter of confirmation of enrollment, which states that the Member Handbook was included with the mailing. Additionally, both the English and Spanish versions of the Handbook are available on the MCO's website. http://passporthealthplan.com/wp-content/uploads/2015/12/MARK-51521-Handbook-2016.pdf The item was additionally addressed in the policy Request for Member Materials in Preferred Language and/or Alternate Formats.		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	Full - The policy MACE 13.0 Member Information and Review Process addresses this requirement.	Non-Compliance	This requirement was not addressed in the review period. The MCO provided Policy MACE 12.1 Member Handbook for New Enrollees as evidence	**Passport's Response** Passport Health Plan has acted upon IPRO's recommendation. Passport has updated our Policy

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**
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		for this requirement. However, this policy was updated after the contract period.	MACE 12.1 Member Handbook for New Enrollees to include the new requirement.  MACE 12 1 Memb Handbook for New
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Full - The MCO provided documentation onsite to address the requirement.			
A. . The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;	Full - The Member Handbook states on page 7 "To view this Directory, please visit http://www.findapassportdoctor.com/. If you do not have access to a computer, you may call Member Services."			
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 pages 9, 10, and 31.	
C. Any restrictions on a Member's freedom of choice among network providers;	New Requirement	Full	This requirement is addressed in the member handbook on pages 9–10.	
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;	Full - This requirement is addressed on page 6 and 7 of the Member Handbook. New Requirement	Full	This requirement is addressed in the member handbook on pages 9–10.	

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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**
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 handbook on page 32.	
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;	Full - The Member Services and 24/7 Nurse Advice Line toll-free telephone numbers, as well as the address and the business hours, can be found on page 2 of the Member Handbook.			
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;	Full - Pages 10-12 of the Member Handbook list the covered and non-covered services. Page 37 of the Member Handbook states that members should not get bills for a covered service or treatment.			
H. Member rights and responsibilities including reporting suspected fraud and abuse;	Full - Page 28-29 of the Member Handbook list member rights and responsibilities, including reporting suspected fraud and abuse.			
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	New Requirement	Full	This requirement is addressed in the member handbook on pages 7, 15, and 16. The right to use any hospital or other setting for emergency care is addressed in the member handbook on page 22 under "When you're out of the service area or out of network."	

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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**
medical services available or to activate emergency medical services by dialing 911;				
J. Procedures for obtaining transportation for both emergency and non-emergency situations;	Full - Page 44 of the Member Handbook describes the covered transportation services, while page 45 lists the transportation brokers available, along with contact information.			
K. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Full - There is information about maternity services on page 24 and family planning on page 25. STD services, family planning, and maternity services are also listed on the covered services list on pages 10-11.			
L. Procedures for arranging EPSDT for persons under the age of 21 years;	Full - Page 39 of the Member Handbook outlines the EPSDT program procedures.			
M. Procedures for obtaining access to Long Term Care Services;	Full - Information on Long Term Care is on page 15 of the Member Handbook.			
N. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Full - This is addressed on page 4 of the Member Handbook.			
O. A list of direct access services that may be accessed without the authorization of a PCP;	Full - Direct access services are listed on page 12 of the Member Handbook.			
P. Information about how to access care before a PCP	Full - This requirement is addressed			

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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**
is assigned or chosen;	on page 7 of the Member Handbook.			
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;	Full - This requirement is addressed on page 19 of the Member Handbook.			
R. Procedures for obtaining Covered Services from non-network providers;	Full - This requirement is addressed on page 20 of the Member Handbook.			
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 on pages 32–36 and outlined in the MS.016.E.KY Grievance Intake Process for Medicaid Legacy and KY HEALTH Policy.	
T. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Full - This requirement is addressed on page 35 of the Member Handbook.			
U. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Full - This requirement is addressed on page 27 of the Member Handbook.			
V. Information on the availability of health education services;	Full - This requirement is addressed throughout the Member Handbook.			
W. Any cost sharing imposed;	New Requirement	Full	This requirement is addressed in the member handbook on page 34.	
X. How to exercise an advance directive;	New Requirement	Full	This requirement is addressed in the member	

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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**
			handbook on page 38.	
Y. Information deemed mandatory by the Department; and	Full - This requirement is addressed throughout the Member Handbook.			
Z. The availability of care coordination, case management and disease management provided by the Contractor.	Full - This requirement is addressed on page 21 of the Member Handbook.			
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.	Substantial-This requirement is mostly addressed on page 20 of the Member Handbook. It is also mostly addressed in the Provider Manual. <u>Recommendation for Passport</u> Please include all specific wording in the listed requirement regarding second opinions into existing policies and procedures. Provision of second opinions on matters related to surgical procedures was not directly addressed in existing documentation. <u>Passport's Response</u> Passport Health Plan has acted upon IPRO's recommendation by including the requirement information in Passport's online Member Handbook. This information will be included via a hard copy in the 2018 Member Handbook.	Full	This requirement is addressed in the member handbook on page 21.	

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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**
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-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.	Full - This includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) The MCO provided monthly reports on call center activities and met all URAC standards.		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).	Full - The MCO operates a 24/7 advice line staffed by RNs.			
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.	Full - This includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). The MCO provided monthly reports on call center activities and met all URAC standards.		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	Full - Page 29 of the Member Handbook states that members can	Full	This requirement is addressed in the member handbook on page 31 and in policies UHC-CLAS	

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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**
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 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.	get an interpreter, as well as information about getting materials in formats for special needs (blind/deaf, etc.). The MCO provided a document which addresses the percentages of members in various counties in the state that do not speak English as a first language. Staff onsite discussed the processes for identifying languages spoken in each county. Policies 13.0 and MS. 11.0 Member Services Department also showed compliance with this regulation. New Requirement		1.04, 1.05 and 1.06.	
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.	Full - The 2017 Provider Manual on page 195 and the 2016 Provider Manual on page 203 states that all providers must comply with the Americans with Disabilities Act. Page 194 of the 2017 manual and page 203 of the 2016 manual addresses that providers maintain environmentally safe offices with equipment in proper working order to comply with city, county, state and federal regulations concerning safety and public hygiene. Both the Provider Manual and the Member Handbook state that members can contact the ombudsman and can have access to their medical records			

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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**
	but it is not connected in any way with being requested in writing and/or cooperation with the Cabinet for Family Services' independent ombudsman program. The policy regarding request of medical records is listed within the policy labeled "Member Right of Access to protected Health information". Recommendation for Passport Passport should review the link on page 195 of the 2017 provider manual because an error occurs when trying to link to the DOJ website.			
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Full - This requirement is addressed in the Member Rights and Responsibilities policy (MS 21.0).			
B. Ensure each Member is free to exercise his or her rights without the Contractor or its Providers treating the Member adversely.	Full - The item is addressed fully in the Member Department Services Function document.			
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 - The item is addressed fully in the Member Department Services Function document.			
D. Monitoring the selection and assignment process of	Full - The item is addressed fully in			

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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**
PCPs;	the Member Department Services Function document.			
E. Identifying, investigating, and resolving Member Grievances about health care services;	Full - The item is addressed fully in the Member Department Services Function document.			
F. Assisting Members with filing formal Appeals regarding plan determinations;	Full - The item is addressed fully in the Member Department Services Function document.			
G. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Full - The item is addressed fully in the Member Department Services Function document.			
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;	Full - The item is addressed fully in the Member Department Services Function document.			
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;	Full - The item is addressed fully in the Member Department Services Function document.			
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	Full - The item is addressed fully in the Member Department Services Function document.			

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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**
impairments);				
K. Explaining or answering any questions regarding the Member Handbook;	Full - The item is addressed fully in the Member Department Services Function document.			
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;	Full - The item is addressed fully in the Member Department Services Function document.			
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	Full - The item is addressed fully in the Member Department Services Function document.			

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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**
Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.				
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Full - The item is addressed fully in the Member Department Services Function document.			
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;	Full - The item is addressed fully in the Member Department Services Function document.			
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.	Full - The item is addressed fully in the Member Department Services Function document.			
Q. Facilitating access to behavioral health services and pharmaceutical services;	Full - The item is addressed fully in the Member Department Services Function document.			
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,	Full - The item is addressed fully in the Member Department Services Function document.			

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**
such as Shriner's Hospital for Children;				
S. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;	Full - The item is addressed fully in the Member Department Services Function document.			
T. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Full - The item is addressed fully in the Member Department Services Function document.			
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;	Full - The item is addressed fully in the Member Department Services Function document.			
V. Facilitating access to Member Health Education Programs;	Full - The item is addressed fully in the Member Department Services Function document.			
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	Full - The item is addressed fully in the Member Department Services Function document.			
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	Full - The item is addressed fully in the Member Department Services Function document.			

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**
method of delivery. A copy of the report shall be provided to the Department.				
31.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.	Full - The Member Handbook on page 37 explains that members should not be billed for any covered services. The item is also addressed in the 2016 Provider Manual on page 49 and in the 2017 Provider Manual on page 51.			
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid Covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.	Full - At the onsite audit, staff explained that members are informed by providers in a signed agreement of all services performed, including those covered and not covered. Additionally, the lock-in program described in the provider manual on page 93, states that lock-in members must be provided the 'Acknowledgement of Responsibility of Payment' form located on the DMS website.			
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	Full - This requirement is addressed			

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**
eligible, adults for whom the state is appointed guardian, disabled children, and foster care children are not required to have a PCP.	on page 7 of the Member Handbook.			
24.2 Member Choice of Primary Care Provider				
Members shall choose or have the Contractor select a PCP for their medical home.	Full - This requirement is addressed on page 7 of the Member Handbook.			
The Contractor shall have two processes in place for Members to choose a PCP: A. A process for Members who have SSI coverage but are not Dual Eligible Members; and B. A process for other Members.	Full - Page 7 of the Member Handbook outlines the process for members to choose a PCP. The MS.071 policy makes a reference to the PCP assignment procedures and how it differs for various groups, including the ones addressed in this requirement.			
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.	Full - The Member Handbook states that members can change their PCP. The MCO provided the policy MS.6.0 Desktop procedures for addressing PCP changes for members.			
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.	Full - There is no explicit wording that states members must select PCP within 10 days of the approved change (e.g. provider termination date). The Coordination of Care due to Provider Termination Policy states that members are given 15 days advanced notification at			

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**
	minimum for PCP involuntary terminations, and 30 days minimum for PCP voluntary terminations. Page 6 of the policy states that fifteen days from distribution of member notifications, members who have not selected a PCP will have one assigned for them. The process of PCP assignments is addressed in the MS 6.0 Desktop Procedures for addressing PCP changes document.			
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 - This item is addressed in the policy MS.006.E.KY Primary Care Providers and in the policy Coordination of Care due to PCP Termination both Voluntary and Involuntary.			
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.	Full - The Member Handbook on page 8 addresses member's rights to choose a PCP. However, the language component of the requirement that states that the assignment will occur no later than the first day of the second month following the month of the request is not addressed in the Member Handbook or in the provided policies and documents. Reviewing the MS.006.E.KY policy and			

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**
	procedure of PCP changes, it states "Member Services will advise the member of the effective date of the PCP change." <u>Recommendation For Passport</u> Please specify or include the specific contract language into existing Member Handbook or into the policy for Primary Care Provider Change. <u>Passport's Response</u> Passport Health Plan respectfully disagrees with IPRO's recommendation and findings to include the specific Contract language in its Member Handbook or into an existing Policy. The language component of the requirement states that the assignment will occur no later than the first day of the second month following the month of the request. This specific language is included in Policy MS.006.E.KY – Primary Care Provider Change. This Policy states that "[A]ll changes are effective the day of the call." This Policy was previously submitted on January 11, 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**
	Final Review Determination This review determination has been changed to Full. The policy MS.006.E.KY – Primary Care Provider Change does contain the language that "[A]ll changes are effective the day of the call." Recommendation for Passport As a recommendation, PHP should also include this language in the Member Handbook.			
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.	New Requirement	Full	This requirement is addressed in the provider manual on page 27.	
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.	Full - This requirement is addressed on page 27 of the Provider Manual.			

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 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.	Full - This requirement is addressed on page 28 of the Provider Manual.			
31.5 Referrals for Services not Covered by Contractor				
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.	Full - Passport complies with the FFS schedules; all participating providers follow the FFS schedules provided by DMS. UM will do authorizations for any non-covered services for providers that are non-par. All providers within the Passport MCO cover FFS therefore meets compliance.			

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	1
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		**2.82**		

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: Passport Health Plan

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.	Full-This requirement is addressed in the Annual Outreach Plan for 2016.			
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.	Full-This requirement is addressed in the Annual Outreach Plan for 2016. The Passport Annual Outreach Plan includes Quality Improvement Activities which addresses educational and creative opportunities for outreach.			
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Full-This requirement is addressed in the Annual Outreach Plan for 2016. The Plan includes the frequency of activities, the staff involved and the effectiveness and barriers for each activity.			
23.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Full-This requirement is addressed in the Homeless Outreach Procedure.			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Full-This requirement is addressed in the Homeless Outreach Procedure.			

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.	Full-This requirement is addressed in the Homeless Outreach Procedure. Transportation assistance is documented in the Member Handbook.			
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:	Full-The item was addressed in the policy PA 13.0 Member information materials and review process. New Requirement	Full	This requirement is addressed in PHP-MACE 13.0 Member Material Development & Approval on page 3.	
A. Be geared toward persons who read at a sixth-grade level and use easily understood language and format;	Full-The item was addressed in the policy PA 13.0 Member information materials and review process. New Requirement	Full	This requirement is addressed in PHP-MACE 13.0 Member Material Development & Approval on page 3.	
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 PHP-MACE 13.0 Member Material Development & Approval on page 3.	
C. Comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Full-The item was addressed in the policy PA 13.0 Member information materials and review process.			
D. Be available through auxiliary aids and services, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in PHP-MACE 13.0 Member Material Development & Approval on page 3.	
E. Be available in alternative formats, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in PHP-MACE 13.0 Member Material Development &	

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**
			Approval on page 3.	
F. Be available in English, Spanish and each prevalent non-English language	New Requirement	Full	This requirement is addressed in PHP-MACE 13.0 Member Material Development & Approval on page 3.	
G. Be provided through oral interpretation services for any language;	New Requirement	Full	This requirement is addressed in PHP-MACE 13.0 Member Material Development & Approval 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 PHP-MACE 13.0 Member Material Development & Approval 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.	Full-This requirement is addressed in the Promotional Items and Member Informational Materials Policy.			
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	Full-This requirement is addressed in the Cultural Competency Training and Education for Providers and Associates Policy. New Requirement	Full	This requirement is addressed in UHC-CLAS 1.09 Cultural Sensitivity Training and Education for Providers and Associates.	

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**
practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.				
The Contractor shall communicate such policies to Subcontractors.	Full-This requirement is addressed in the Cultural Competency Training and Education for Providers and Associates Policy and Procedure.			

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

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
39.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.	Full-This requirement is addressed in policy and procedure QI.033.E.KY Medical Records Standards and Review, which outlines the plan's medical record policy and procedure. Policy and procedure QI.033.E.KY includes Attachment A, which documents the plan's medical record keeping standards.			
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in the Confidentiality of Records section.	Full-This requirement is addressed in policy and procedure QI.033.E.KY. It is also addressed in the Provider Manual under section 3.0.			
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Full-This requirement is addressed in QI.033.E.KY Medical Record Standards and Review.			
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of	Full-This requirement is addressed in PASSPORT's provider contract in section 3. Provider's Obligations and 6. Records.			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.				
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.	Full-Medical record audits are addressed in QI.033.E KY Medical Record Standards and Review. Procedures for failed audits are outlined in policy and procedure PR 136.0 Failed Medical Record Audit-Process for Follow Up with Provider.			
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:	Full-Passport Health Plan addressed this requirement by updating QI.033.E.KY Medical Record Standards & Review to include PCP and multi-specialty groups.			
A. Demonstrate the degree to which	Full-As per QI.033.E.KY, the purpose of medical			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
providers are complying with clinical and preventative care guidelines adopted by the Contractor;	record review includes evaluation of provider compliance with clinical practice guidelines. Results were provided in activity summary documents.			
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Full-This is addressed in policy and procedure QI.033.E.KY. Results of audits are logged and maintained in a database; practitioners not meeting the 80% compliance threshold are notified of results and actions for improvement and re-reviewed. As per policy and procedure PR 136.0 unresolved trends are referred to Credentialing Committee.			
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and	Full-This requirement is addressed in QI.033.E.KY, policy and procedure 136.0 and the Provider Manual.			
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.	Full-This is addressed in the Utilization Management and Clinical Programs Description and the 3rd Quarter Utilization report as well as the 2015 Utilization Management and Clinical Programs Evaluation.			
28.7 Provider Maintenance of Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital	Full-This requirement is addressed in policy and procedure QI.033.E.KY. This requirement is also addressed in the Provider Manual provided by the plan, specifically, section 3.4.2 Medical Records.			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Member's Medical Record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).	Full-Access to medical records is addressed in QI.033.E.KY and policy and procedure PHP 23. This is also addressed in the contract agreements with the plan. The right to obtain a copy of the medical record is included in Member Handbook and provider agreement. The requirement to maintain medical records for a minimum of five years is included in provider contract agreements.			
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:	Full-This requirement is addressed in policy and procedure QI.033.E.KY. This requirement is also addressed in the Provider Manual, specifically, section 3.2 The Role of the Primary Care Provider.			
A. Member/patient identification information, on each page;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A. This			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	requirement is also addressed in the Provider Manual.			
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;	Full-This requirement is addressed in policy and procedure QI.033.E.KY. This requirement is also addressed in the Provider Manual.			
C. Date of data entry and date of encounter;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A. This requirement is also addressed in the Provider Manual.			
D. Provider identification by name;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A. This requirement is addressed in the Provider Manual.			
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A. This requirement is also addressed in the Provider Manual provided by the plan. Specifically, the 4.5 Medical-Record-Keeping & Continuity & Coordination of Care Standards.			
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);	Full-This requirement is addressed in QI.033.E.KY Medical Record Standards and Review. This requirement is addressed in the Provider Manual.			

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
G. Identification of current problems;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A .This requirement is also in the Provider Manual.			
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A .This requirement is also in the Provider Manual.			
I. Documentation of immunizations pursuant to 902 KAR 2:060;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A .This requirement is also in the Provider Manual.			
J. Identification and history of nicotine, alcohol use or substance abuse;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A .This requirement is also in the Provider Manual.			
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A.			
L. Follow-up visits provided secondary to reports of emergency room care;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A.			
M. Hospital discharge summaries;	Full-This requirement is addressed in policy and procedure QI.033.E.KY, Attachment A.			
N. Advanced Medical Directives, for adults;	Full-This requirement is addressed in policy and procedure QI.033.E.KY. This information is communicated to providers in the Provider Manual under section 3.4.4 Advance Directives.			
O. All written denials of service and the	Full-This requirement is addressed in policy and			

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reason for the denial; and	procedure QI.033.E.KY Attachment A.			
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.	Full-This requirement is addressed in policy and procedure QI.033.E.KY Attachment.			
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;	Full-This requirement is addressed in policy and procedure QI.033.E.KY Attachment A and the Provider manual.			
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and	Full-This requirement is addressed in policy and procedure QI.033.E.KY Attachment A and the Provider manual.			
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.	Full-This requirement is addressed in policy and procedure QI.033.E.KY Attachment A and the Provider manual.			
28.8 Advance Medical Directives				

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.	Full-This requirement is addressed in the Provider manual and member handbook. This is also addressed in the Advance medical directive policy PHP-CC-29 0.			
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.	Substantial-This information is included in the Member Handbook on page 2. This information is also addressed in the Provider Orientation Kit, specifically, the Member Rights section, the Advanced Medical Directive Policies for Members and Providers policy and the PR 120.0 - Advance Directives Training for Providers policy. However, the requirement for the member to be notified within 90 days of any changes in the rules and regulations is not included. <u>Recommendation for Passport</u> Members should be notified of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change <u>Passport Response:</u> Passport Health Plan has acted upon IPRO's recommendation by including the requirement information in Passport's online Member Handbook. This information will be included via a	Full	This requirement is addressed in the member handbook on page 38, the provider manual on pages 34 and 45, and in the CC.290.E.KY Advanced Medical Directives Policy.	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	hard copy in 2018.			
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.	Full--This requirement is addressed in the manual, specifically, page 48.			
39.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in the Health Insurance Portability and Accountability Act section of this contract.	Full-This is addressed in the provider agreement section 6. Records.			
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or	Full-This requirement is addressed in policy and procedure QI.033.E.KY Attachment A and the Provider manual.			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.				
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Full-This is addressed in the DMS BAA document. This is also addressed in the provider contracts. In addition The Employee handbook discusses employee confidentiality. Each employee is required to sign and acknowledgement that he/she received the Employee Handbook.			
Except as otherwise required by law, regulations or this Contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.	Full-This requirement is addressed in the provider manual, page 42.			
41.15 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the	Full-This requirement is addressed in policy and procedure IT 31.00 HIPAA and HITECH Security			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as are the Contractor.	Compliance Policy. In addition, the plan provided the Provider Manual and highlighted under section 3.1 Confidentiality.			

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

Final Findings

Medical Records

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

Medical Records

Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Provider compliance assessment/monitoring results and follow-up

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.2 Requirements for Behavioral Health Services				
The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Members with SMI and SED, including Members with co-occurring developmental disabilities, substance use disorders and smoking cessation. The Contractor in its design and operation of behavioral health services shall incorporate these core values for Medicaid Members: A. Members have the right to retain the fullest control possible over their behavior health treatment. Behavioral health services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare. B. The Contractor shall provide the most normative care in the least restrictive setting and serve Members in the community to the greatest extent possible. C. The Contractor shall measure Members' satisfaction with the services they receive. D. The Contractor's behavioral health services shall be recovery and resiliency focused.	Deemed for 2017			
34.3 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix H.	Full - This requirement is addressed in the UM 202.06 Application of Level of Care Criteria and Authorization Procedures for Medicaid document.			
All Behavioral Health services shall be provided in	Full - This requirement is addressed in the UM			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
conformance with the access standards established by the Department. When assessing Members for Behavioral Health Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM.	202.06 Application of Level of Care Criteria and Authorization Procedures for Medicaid document.			
Providers shall document DSM diagnosis and assessment/outcome information in the Member's medical record.	Full - This requirement is addressed in the UM 92.16-Information for UM Medical Necessity Review and Reimbursement to Providers for Medical Records on page 2.			
34.4 Behavioral Health Provider Network				
The Contractor shall provide access to Psychiatrists, Psychologists, and other behavioral health service providers.	Full - Includes review of MCO Report #12A Geo Access Network Reports & Maps and MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results) This requirement is addressed in the Desk-Audit_Quarterly-Reports-2016 document on Sheet 1. It is also addressed in QM 24.23 Measurement of Availability and Accessibility of Clinical Services.		Includes review of MCO Report #12A Geo Access Network Reports & Maps and MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results).	
Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of behavioral health services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations,	Full - The plan addressed this requirement with the submission of their master file that contained a listing of CMHCs. The provider manual also lists the behavioral providers that are available in their network.			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Licensed Clinical Social Workers, Certified Family, Youth and Peer Support Providers, Targeted Case Managers and other independently licensed behavioral health professions.				
To the extent that non-psychiatrists and other providers of Behavioral Health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Full - The plan addressed this requirement with the submission of their master file that contained a listing of FQHCs and RHCs. Copies of provider contracts were also provided as evidence. Also evidenced in the GEO Access reports. Recommendation for Passport The requirement for Passport to have these providers in their network should be included in a policy. Passport's Response Passport Health Plan has acted upon IPRO's recommendation by updating Policy PR 13.0 – Access and Availability Standards to include these Providers.	Substantial	The MCO submitted PR 13.0 Access and Availability Standards- Procedure and PR 13.0 Access and Availability Standards-Policy (revised 5/15/18 and 3/27/18, respectively). Neither of these two documents references FQHC and RHC providers as being a part of their network, as the MCO indicated they would in last year's response. The MCO submitted PR 302.4 Network Design, Access and Availability Standards, which cites facilities (the MCO can consider listing FQHCs and RHCs among the examples of facilities that are given). Note that this policy does not provide Kentucky-specific standards. The MCO should consider an additional exhibit to include in this policy. However, it is evident that these facilities participate in the MCO's behavioral health (BH) network (per the 2017 GeoAccess report that was submitted, for example).	**Passport Response** Passport acknowledges IPRO's recommendation.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for MCO The MCO should include the requirement to have these facilities (FQHCs and RHCs) in their BH network in policies PR 13.0 and PR 302.4.	
34.5 Member Access to Behavioral Health Services				
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Full - This requirement is addressed in the QM 24.23-Measurement of Availability and Accessibility of Clinical Services document.			
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services. The Member Manual shall contain information for Members on how to direct their behavioral health care, as appropriate.	Full - This requirement is addressed in the CSNT 105-Member's Rights and Responsibilities document.			
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.	Full - This requirement is addressed in the CSNT 105-Member's Rights and Responsibilities document.			
34.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth.	Full - This requirement is addressed in the CUR 135.0-Clinical Coverage and Access to Utilization Management Staff document.			
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health	Full - This requirement is addressed in the CUR 135.0-Clinical Coverage and Access to Utilization Management Staff document.			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
emergencies.				
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Full - This requirement is addressed in the CUR 135.0-Clinical Coverage and Access to Utilization Management Staff document.			
The Behavioral Health Services Hotline shall not be answered by any automated means.	Full - This requirement is addressed in the CUR 135.0-Clinical Coverage and Access to Utilization Management Staff document.		Includes placing a call to the BH Services Hotline to confirm that hotline is not answered by any automated means.	
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs:	Full-Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the CUR 142.0-Member Services and Clinical Referral and Triage Process document.		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring;	Full - Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the PP_Reports_160131_Report11 – Updated document.		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)..	
B. No incoming calls receive a busy signal;	Full - Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the PP_Reports_160131_Report11 – Updated document.		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
C. The call abandonment rate is seven percent (7%) or less; and	Full - Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	This requirement is addressed in the PP_Reports_160131_Report11 – Updated document.			
D. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.	Full - This requirement is addressed in the CUR 142.0 Member Services and Clinical Referral and Triage Process under section Emergency/Crisis Call Procedures.			
The Contractor may operate one hotline to handle emergency and crisis calls.	Full - This requirement is addressed in the PP_Reports_160331_Report11 – Update document.			
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	Full - This is addressed in the Passport Health Plan Behavioral Health/Substance Abuse Cheat Sheet in the first paragraph. Recommendation for Passport This information should be added to a member services policy and if it remains in the cheat sheet it should be further addressed and not part of "Who is Beacon." **Passport Response** Passport Health Plan has acted upon IPRO's recommendation by updating Policy MS.011.E.KY – Member – Provider- Care Connector Service Department Function – to include no maximum call duration limits	Substantial	The MCO submitted MS.011.E.KY – Member – Provider- Care Connector Service Department Function (last updated 5/2018). There is no indication that maximum call duration limits are addressed in this policy. On site, the MCO provided an update to this policy to reflect no maximum call duration limits. **Recommendation for MCO** The MCO should substitute this revised policy for the original policy, as it appropriately cites the requirement.	**Passport Response** Passport acknowledges IPRO's recommendation. Policy MS.011.E.KY Member-Provider Care Connector Service Department Function was revised and replaced the previous version. MS.011.E.KY Member-Provider-Ca
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Full - This requirement is addressed in the QM 24.23-Measurement of Availability and Accessibility of Clinical Services document.			

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs.	Full - Passport has a separate dedicated Beacon call in hotline number.			
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full - This requirement is addressed in the QM 24.23-Measurement of Availability and Accessibility of Clinical Services document.			
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full - Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the PP_Reports_160131_Report11 – Updated document.		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results).	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
34.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department for approval.	Full - This is addressed in Appendix A of the PCP contract. This is also addressed via Passport's provider web site under the Screening, Brief Intervention, and Referral to Treatment (SBIRT).			
The Contractor shall provide training to network PCPs on	Full - This requirement is partially addressed in	Substantial	HR 1130.3 Training Policy was	**Passport Response**

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.	the HR 1130.1 Training document. This is also addressed via Passport's provider web site under the Screening, Brief Intervention, and Referral to Treatment (SBIRT).		submitted, and minimally meets this requirement; training related specifically to how to screen for and identify BH disorders and referral processes for BH services; however, coordination and quality of care are not referenced. The MCO did, however, submit "BH Orientation Presentation," which provides an overview of the MCO's collaboration with Beacon Health Strategies to assist in the delivery of BH services. This presentation is found on the MCO's website in the section for providers. This requirement is addressed within the MCO's provider website under educational resources/screening, brief intervention, and referral to treatment (SBIRT). **Recommendation for MCO** The MCO should ensure that their internal policies and procedures reference how network providers should be trained in order to screen for and identify BH disorders, as well as the MCO's referral processes for BH services and clinical coordination for such services.	Passport acknowledges IPRO's recommendation. The 2018 Passport Health Plan BH Cheatsheet has been revised to include the additional language.
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical	Full-Includes BH/PH Care Coordination file review summary results		Includes behavioral health/physical health (BH/PH) care coordination file	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
coordination between Behavioral Health Service Providers and PCPs.	This requirement is addressed in the CCM 102.1 Collaboration & Referral document. BH/PH Care Coordination File Review 10/10 files included documentation of comprehensive assessment, and care plans. 7/7 files were compliant for identification and coordination of care for physical and behavioral health. 3 were NA. 9/9 of the files were compliant for review for discharge planning. 1 case the discharge planning was unable to be determined since the member left the hospital and was not able to be contacted.		review summary results.	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Full - This requirement was addressed in the CCM 122 Intensive Case Management Program document.			
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.	Full - <u>Final Review Determination</u> This determination was changed to Full. This requirement is addressed in the Provider Manual, section 16.5 Quality Improvement. <u>Passport's Response:</u> Passport provided documentation related to this			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	requirement. Please see the Provider Manual, page 177. Passport provided this document on January 11, 2017.			
34.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.	Full - This requirement was addressed in the CUR 137.0-Documentation of Aftercare Following Mental Health Hospitalization document.			
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full - This requirement was addressed in the CUR 137.0-Documentation of Aftercare Following Mental Health Hospitalization document.			
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	Full - This requirement was addressed in the CUR 133-Behavioral Health Treatment and Discharge Planning document.			
34.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.	Full - This requirement is addressed in the UM 202 ADDENDUM Application of Level of Care KY document.			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Full -This requirement is addressed in the UM 202 ADDENDUM Application of Level of Care KY document.			
34.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
A. The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law and/or voluntarily admitted to the state psychiatric hospital.	Full - This requirement was addressed in the KY SOP Comm Tx of State Hospital Discharges 10 12 16 document.			
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.	Full - This requirement was addressed in the KY SOP Comm Tx of State Hospital Discharges 10 12 16 document.			
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.	Full - This requirement was addressed in the KY SOP Comm Tx of State Hospital Discharges 10 12 16 document.			
B. The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the	Full -This requirement was addressed in the KY SOP Comm Tx of State Hospital Discharges 10 12			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
date of discharge and provide basic, targeted or intensive case management services as medically necessary to Members with severe mental illness (SMI) and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with SMI.	16 document.			
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.	Full - This requirement was addressed in the KY SOP Comm Tx of State Hospital Discharges 10 12 16 document.			
Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.	Full - This requirement was addressed in the KY SOP Comm Tx of State Hospital Discharges 10 12 16 document.			
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.	Full - This is addressed in the Provider manual under section 16.5.3, Accessing Medications.			
34.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);	Full - This requirement is addressed in the BEACON 2016 Corporate and Service Center QMPD and Work Plan document as well as the following policies: PR 13.0 Access and Appointment Availability Standards and CREF 101-105 Member Request Risk Ratings.			
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	Substantial - Passport provided its Annual Report on Psychotropic Drug Intervention Program (PDIP) and monthly dashboards. Evidence could not be found to support the exchange of information among the providers. <u>Recommendation for Passport</u> Passport should assure that this information is provided to its providers through the provider portal or newsletters. **<u>Passport's Response:</u>** Passport Health Plan has acted upon IPRO's recommendation by internal departments, Provider Network Management and Pharmacy Department, working together to identify the information which can be shared among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions and how we can facilitate this through newsletters or the provider website as educational materials	Full	This requirement is addressed in the 2018 Passport Pharmacy Program Description, wherein the objectives indicate the MCO seeks to support communication and flow of information between the chief medical officer, P&T Committee, providers, and the pharmacy benefits manager. In addition, the MCO demonstrated their provider portal which contains drug safety alerts.	
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;	Full - This requirement is addressed in the BEACON 2016 Corporate and Service Center QMPD and Work Plan document.			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Protect the confidentiality of Member information and records; and	Full - This requirement is addressed in the BEACON 2016 Corporate and Service Center QMPD and Work Plan document.			
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full - This requirement is addressed in the BEACON 2016 Corporate and Service Center QMPD and Work Plan document.			
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

Final Findings

Behavioral Health Services

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.25**		

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

Behavioral Health Services

Suggested Evidence

Documents

Policies/procedures for:

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

Benefit Summary (covered/non-covered BH services)
Provider Manual
Sample PCP contract
Sample BH provider contract
Process for educating members of where and how to obtain BH services
Process for monitoring compliance with hotline requirements
Process for educating PCPs of BH services/requirements
Evidence of training of PCPs regarding BH services/requirements
Sample participation agreement with CMHCs
Sample collaborative agreement with state operated or state contracted psychiatric hospitals
Process for coordination of services for members committed by court of law to the state psychiatric hospital
Guidelines/procedures ensuring accessibility, availability, referral and triage including emergency BH services
Process for facilitating the exchange of pharmaceutical information among providers
Process for evaluating continuity and coordination of care among providers
QI Plan
Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Final Findings

Reports

Geo Access network reports and maps (MCO Report #12A) for behavioral health services including mental health and substance abuse providers
Access and delivery network narrative reports (MCO Report #13)
Reports of access and availability of BH providers
Evidence of monitoring of compliance with hotline requirements (MCO Report #11)
Evidence of ensuring follow-up after hospitalization for BH services
Evidence of monitoring compliance with BH standards

File Review

BH/PH Coordination files for a random sample of cases chosen by EQRO

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Passport Health Plan

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;	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 10.			
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;	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 5.			
C. Retrospective drug utilization review (RetroDUR) services;	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 21.			
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, a PA escalation process and procedure, an appeals	Full - Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports)		Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior	

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**
process, and a Pharmacy and Therapeutics Committee (P&T);	This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 9.		Authorizations (see Quarterly Desk Audit Reports. Q4 2015 results were not reviewed since they were not available at the time of the compliance review).	
E. Pharmacy Provider relations and education, and call center services (member and provider), in addition to provider services specified elsewhere;	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 10.			
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 16.			
G. Claims payment services;	Full - This requirement is addressed in: Medicaid Claims Adjudication document (Figure A. page2).			
H. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 15.			
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: 2016 Prescription Benefit Services Agreement, page 16 and 20.			

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 DOC-049469 Medicaid Claims Adjudication Policy.	
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:	Full - This requirement is addressed in: 2016 Prescription Benefit Services Agreement, page 8.			
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	Full	1) This requirement is addressed in RX.060.E.KY Prior Authorization of Pharmaceuticals and RX.063.E.KY Communicate Pharmacy Procedure Changes policies. 2) This requirement is addressed in the RX.059.E.KY Preferred Drug List Policy. 3) This requirement is	

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.			addressed in RX.051.E.KY Pharmacy and Therapeutics Advisory Committee Policy on page 1. 4) This requirement is addressed in the RX.059.E.KY Preferred Drug List Policy. 5) This requirement is addressed in the RX.059.E.KY Preferred Drug List Policy. 6) This requirement is addressed in RX.051.E.KY Pharmacy and Therapeutics Advisory Committee Policy on page 2.	
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 Passport Health – Prescription Benefit Services Agreement: Participating Customer Agreement.	
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	New Requirement	Full	These requirements are addressed in: 1) RX.060.E.KY Prior Authorization of Pharmaceuticals and RX.063.E.KY Communicate Pharmacy Procedure Changes policies. 2) Passport Health – Prescription Benefit	

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**
specified in 42 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.			Services Agreement: Participating Customer Agreement on page 10. 3) Passport Health – Prescription Benefit Services Agreement: Participating Customer Agreement on page 9.	
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.	Full - This requirement is addressed in: 2016 Prescription Benefit Services, page 69.			
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 - This requirement is addressed in: 2016 Prescription Benefit Services, page 5.	Full	This requirement is addressed in Passport Health – Prescription Benefit Services Agreement: Participating Customer Agreement on page 5.	

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.	Full - This requirement is addressed in: 2016 Prescription Benefit Services, page 61.			

Final Findings

Pharmacy Benefits

Scoring Grid:

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

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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)