2019 Documentation and Reporting Tool
For Recording UNITED HEALTHCARE Compliance with State Contract Requirements

This tool contains three components:

1) First, it presents a subset of the State KanCare 2.0 Contract requirements as well as supporting notes and definitions. Contract areas have been divided into distinct parts to facilitate compliance determination.

2) Next to each State Contract requirement is space for indicating the extent to which an MCO is in compliance with the requirement. Five possible compliance designations are presented: "Fully Met (FM)," "Substantially Met (SM)," "Partially Met (PM)," "Minimally Met (MM)," and "Not Met (NM)." In addition, the category Not Applicable ("N/A") has been added, since some requirements may not apply to the MCO. The compliance definitions are as follows:

   Full Compliance (Fully Met) 100%:
   - All documentation listed under a State contract area, or component thereof, is present; and
   - MCO staff provide responses to reviewers that are consistent with each other and with the documentation; or
   - A State-defined percentage of all data sources – either documents or MCO staff provide evidence of compliance with State contract areas.

   Substantial Compliance (Substantially Met) 75%:
   - After review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as stated above.

   Partial Compliance (Partially Met) 50%:
   - All documentation listed under a State contract area, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or
   - MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or
   - Any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a State contract area would result in a "Partially Met" designation for the provision as a whole.

   Minimal Compliance (Minimally Met) 25%:
   - After review of the documentation and discussion with MCO staff, it is determined that although some contract requirements have been met, the MCO has not met most of the contract requirements.

   Non-compliance (Not Met) 0%:
   - No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with State contract requirements; or
   - No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the State) of a multi-component provision, regardless of compliance determinations for remaining, non-key components of the provision.

3) Below each grouping of State Contract Requirements, space is provided to allow reviewers to reference documentation or other evidence supporting the compliance designations.

1. Contract Area: Spenddown	FM	SM	PM	MM	NM	NA
Spenddown: The State will provide a sample of 10 members with QMB and Spenddown. Provide the file for each member. Provide documentation as to how the claims for services provided to those members between Jan and July 2019 were adjudicated. Ensure that the documentation clearly demonstrates how spenddown was handled and the impact of spenddown on claim adjudication.						X
Provide a summary narrative to explain the process and the results for each of the 10 members.						X
Documentation: Special Terms and Conditions: #17 (Eligibility Groups Affected By the Demonstration); #19 (Exemption); and #81 (Reporting Expenditures Under the Demonstration); **Contract Section:** 6.5 Categories of Eligibility; and **KanCare Guide:** pages 171-184						
Desk Review Comments: : Spenddown was not audited for the 2019 contract year. The audit process for Spenddown is being modified and review will be conducted in 2020.						

Contract Area: Assignment	FM	SM	PM	MM	NM	NA
5.5.13 Delegation Relationships The requirements of this section apply to any contract or written arrangement that the CONTRACTOR(S) has with any Subcontractor. If any of the CONTRACTOR(S)' activities or obligations under this CONTRACT are delegated to a Subcontractor, the CONTRACTOR(S) shall: **5.5.13.K** No delegate or enter into a Subcontract or a comprehensive management services agreement to perform key operational functions that are critical for integrated health care service delivery, including, at a minimum: 1. Grievance and Appeal System 2. Quality Management 3. Medical Management 4. Provider Relations 5. Network and Provider Services Contracting and Oversight 6. Member Services 7. Corporate Compliance						
5.5.13.L Each Subcontract, and, upon the request of the State, any further delegations by a Subcontractor, shall be subject to review and/or written approval by the State.			X			
Documentation for 5.5.13.; 5.5.13.K.; and 5.5.13.L.						
Desk Review Comments: Regarding **5.5.13.L.** Meets the requirement 5.5.13.K. Partially meets requirement 5.5.13.L. For requirement 5.5.13.L the contracts team requests UHC provide the subcontractor contracts listed in the 2019 KS KFMC KDHE BBA and State Contract Audit Narrative for review and records. We do have the Logisticare (NEMT) in our files.						

Contract Area: Contractor Staffing	FM	SM	PM	MM	NM	NA
5.1.4.1.E Contractor(s) must develop a Business Continuity Plan which includes the following: **5.1.4.1.E.7.a** Replacement in the event of loss of personnel before or after signing this CONTRACT; **5.1.4.1.E.7.c** Allocation of additional resources to the CONTRACT in the event of inability to meet any performance standard; **5.1.4.1.E.7.c.i** Replacement/addition of personnel with specific qualifications; **5.1.4.1.E.7.c.ii** Timeframes necessary for replacement; and **5.1.4.1.E.7.c.iii** Capability of providing replacements/additions with comparable experience. The method of bringing replacements/additions up to date regarding the Kansas CONTRACT must be emphasized.	X					
Documentation for 5.1.4.1. E.; and related sub-sections; Business Continuity Plan						
Desk Review Comments: Documentation about general staff contingency planning is evident so the requirement is fully met for regular staffing. Need to also see how recruitment takes place for filling key positions, timeframes for the recruitment and training to understand the Kansas contract for the key personnel.						

Contract Area: Coordination and Continuation of Care	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.4.1.A The CONTRACTOR(S) shall be responsible for Service Coordination and continuity and continuation of care by establishing a set of Member-centered, goal-oriented, culturally relevant, and logical steps to ensure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Case Management, disease management, discharge planning, and transition planning are elements of Service Coordination for Members across all Providers and settings. Service Coordination shall also assist Members with addressing Social Determinants of Health and Independence. **5.4.1.C** The CONTRACTOR(S)' Service Coordination program shall at a minimum include the following elements: **5.4.1.C.11** A process to assure referrals for medically necessary, specialty, secondary, and tertiary care and a person designated as primarily responsible for coordinating the health care services furnished to the Member; and **5.4.1.C.12** Provision of systems to assure provision of care in emergency situations, including an educational process to help assure that Members know where and how to obtain medically necessary care in emergency situations.		**X**				
Documentation for 5.4.1.A.–5.4.1.C.12 Coordination and Continuation of Care, Transition Plan for Members:						
Desk Review Comments: All requirements met with exception of 5.4.1.C.12. Auditor was not able to locate this specific language in any of the documents provided.						

Contract Area: Customer Service	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.10.10.F The CONTRACTOR(S) must provide language assistance and translation services necessary to ensure meaningful access at no cost to the LEP Members. **5.10.10.I** The CONTRACTOR(S) must provide a system to track and document all phone contacts, including incoming calls, outgoing calls, incoming email, outgoing email, web-based contacts and voice messages. The call tracking system shall have the capability to generate statistical reports regarding, for example, call volumes, length of time to answer, abandonment rates, length of the calls, nature of the contact and who answered the contact. **5.10.10.K.1** One hundred percent (100%) of incoming and outgoing calls must be documented and recorded. The CONTRACTOR must provide other services as directed by the State. The CONTRACTOR must provide a detailed description of its proposed solutions in its response and describe how it will operate the customer service center. **5.10.10.K.2** Ninety-nine percent (99%) of calls will be answered by an individual or an electronic device without receiving a busy signal. **5.10.10.K.4** Ninety percent (90%) of calls answered will be resolved by the CONTRACTOR(S) during the initial contact. The CONTRACTOR must provide interpreter service, bilingual service, TDD, etc. **5.10.10.K.6** One hundred percent (100%) of calls left on voice mail during or after working hours will be retrieved and returned within one (1) business day. **5.10.10.K.12** Ninety-five percent (95%) hold times equal to or less than one (1) minute for all inbound and outbound calls.	**X**					
Documentation for 5.10.10.F, I, K.1-2, K.6, and K.12 Customer Service						
Desk Review Comments: UHC submitted documentation to support the contractual requirements. **Bobbie Graff-Hendrixson** No onsite audit was conducted for the 2019 review year.						

Contract Area: Financial - Disclosure of Financial Records	FM	SM	PM	MM	NM	NA
5.13.1.A The CONTRACTOR(S) shall establish and maintain an accounting system in accordance with generally accepted accounting principles, and the revenues and expenses properly applicable to this CONTRACT shall be readily ascertainable. **5.13.1.B** The CONTRACTOR(S) and any Subcontractors shall make available to the State, the State's authorized agents, and appropriate representatives of the HHS, any financial records of the CONTRACTOR(S) or Subcontractors which relate to the CONTRACTOR(S)' capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this CONTRACT. Accounting procedures, policies and records shall be completely open to state and Federal audit at any time during the CONTRACT period and for ten (10) years thereafter.		X				

Documentation for 5.13.1.A and 5.13.1.B Disclosure of Financial Records:

Desk Review Comments: 5.13.1.A UHC had indicated they use PeopleSoft 9.2. Their subcontractors are using PeopleSoft 9.2 or Epicor Software 7.4 SP7 and support is either contracted annually or included in the version they maintain.

UHC provided the "subcontractor" tab of the KanCare financial package in response to the request to provide Subcontractor financials. Financial reporting needs to come from the subcontractor in the event they are requested.

Onsite Review Comments: UHC had indicated they use PeopleSoft 9.2. Their subcontractors are using PeopleSoft 9.2 or Epicor Software 7.4 SP7 and support is either contracted annually or included in the version they maintain.

UHC provided the "subcontractor" tab of the KanCare financial package in response to the request to provide Subcontractor financials. Financial reporting needs to come from the subcontractor in the event they are requested.

Does the plan review financial records of its subcontractors? If so, how often? Yes, they are reviewed on an annual basis. Some affiliated subcontractors are getting more frequent review as part of corporate consolidation.

Does United have a retention policy? Please provide. Yes, detailed Records Retention Schedule in place. Policy provided. However, retention length only indicates 10 years when it needs to be contract period and 10 years thereafter.

How does the plan ensure the retention policy is followed? Policy delineates responsibility to the Enterprise Records Information Management department and requires that every employee follow the policy. All employees receive training on this topic via online curriculum training at first hire. There is visibility five years back. Entity is heavily audited, so can pull detail from archives if data from further back is needed.

Does the plan require its subcontractors to have retention policies? If so, where is this documented? For affiliated subcontractors, yes, it's in the corporate level policy. Validation is done for external subcontractors.

Contract Area: Financial - Payment	FM	SM	PM	MM	NM	NA
5.5.15 Provider Payment **5.5.15.A.1** Minimum Reimbursement to Participating Providers: For Participating Providers, the published Medicaid FFS rate shall be the rate that would be received in the FFS Medicaid program inclusive of options for quality and Outcomes incentive payments.	**X**					
Documentation for 5.5.15 Provider Payment; and 5.5.15.A.1 Minimum Reimbursement						

Desk Review Comments: UHC indicated the arrangement their NEMT provider, Logisticare, has with its providers which is below FFS. These types of arrangements must be prior approved by the State. UHC also has a capitated VBP arrangement with Children's Mercy which is also prior approved by the State.

Onsite Review Comments:

The following questions were posed to UHC on site:

1. **What is the process you have in place to be able to observe a payment floor of 100% for your providers?** This is done by looking at encounters. The Provider Advocate Team reviews encounters on a monthly basis and is hiring a person for which this will be their sole responsibility. Quality reviews are done quarterly and annually by Deloitte as part of internal controls review. Contractually providers are at 100% FFS.
2. **What is the process you have in place to be able to observe your subcontractors' payment floor of 100% to their providers?** Monthly review by provider network team which has visibility to contracted rates. The provider network team performs reviews to ensure contract compliance.
3. **Are quality and incentive payments issued to your providers? If so, are they in addition to the FFS payment?** Yes.
4. **Do your subcontractors provide incentive payments to their providers?** Yes. **If so, are they in addition to the FFS payment?** No incentive model yet but there will be for Optum Behavioral Health in the future.
5. **How do you handle complaints from providers regarding payment below 100% FFS?** These are handled by the Provider Advocate Team, but currently there aren't any that are under FFS in aggregate. For national contracts (lab entities) some fees are over FFS and some below, but these are approved by the State team.

Contract Area: Financial – Physician Incentive Plans	FM	SM	PM	MM	NM	NA
5.7 CONTRACTOR(S) Proposals for Value-Based Models and Purchasing Strategies **5.7.1.A** Value-Based Models and Purchasing Strategies **5.7.1.A.1** Alternate Payment Models (APMs) Any proposed APMs that impose risk on the Provider must be consistent with the physician incentive plan requirements specified in 42 CFR § 438.3(i) and must be approved by the State prior to implementation. **5.9.5** Performance Improvement Projects	X					
Documentation for 5.7.A Value-Based Models and Purchasing Strategies; 5.7.1.A.1 APMs; and 5.9.5 PIPs						
Desk Review Comments: None **Talya Quick**						
Onsite Review Comments: The following questions were posed to UHC on site: 1. **How do you ensure that your PIPs do not reduce or limit medically necessary services?** All PIPs are upside only. Quality metrics must be met, otherwise there is no benefit. **2. Do any of your subcontractors us PIPs? If so, how do you ensure that your subcontractors PIPs do not reduce or limit medically necessary services?** CMHCs have upside PIP regarding quality improvements. Optum has upside PIP regarding medication review whereby adherence, quality, and safety are reviewed. **3. How do you ensure that providers, physicians or entities you enter into PIPs with have adequate stop loss coverage?** Children's Mercy is the sole downside risk and their 990s and financial statements are reviewed by the Delegation Oversight Cmte. They are vetted financially to ensure resources and infrastructure can handle the risk. **4. How do you ensure that subcontractors' PIPs have adequate stop loss coverage?** Currently, no one in KS is capable of downside risk.						

Contract Area: Enrollment, Marketing, and Disenrollment	FM	SM	PM	MM	NM	NA
5.10.6.A The CONTRACTOR(S) shall provide information for approval to the State and then the CONTRACTOR(S) will print information to be included with the welcome packet per State printing specifications for Members and potential Members in accordance with 42 CFR § 438.10(e) that includes requirements documented in section 5.10.6.A.1-14.	X					
5.2.1.K.2 If a Member does not select a PCP within ten (10) business days of enrollment, the CONTRACTOR(S) must make an automatic assignment, taking into consideration such factors, if known, as current Provider relationships, language need, cultural competency, and area of residence.	X					
5.2.1.C.1 Members will be informed that they may request and be assigned a new PCP at any time. The welcome packet will include PCP enrollment materials, Member ID card, a Member handbook, a provider listing and Member's rights and responsibilities.	X					
Documentation for 5.10.6.A Welcome Packet; 5.2.1.K.2 PCP Assignment; and 5.2.1.C.1. PCP Selection						
Desk Review Comments: Fully met; no comments.						

Contract Area: Functions and Duties of the Contractor-SUD Licensing	FM	SM	PM	MM	NM	NA
Attachment C Services, Section 3.3.2.4 The CONTRACTOR(S) shall provide assurance that any Providers delivering services are licensed as required by applicable State laws. Currently State law also requires that any Provider of SUD treatment services in a facility setting be licensed by KDADS/BHS to provide SUD treatment services; that any Provider determining the medical necessity of such services according to the Kansas definition must be a Behavioral Sciences Regulatory Board (BSRB)-licensed practitioner practicing within their scope as defined by the BSRB.						X
Documentation for Attachment C, 3.3.2.4. Substance Use Disorder Provider Licensing: It was determined that licensing activity for SUD providers is managed by Kansas Behavioral Sciences Regulatory Board**,** a State agency independent of KDHE and KDADS. This focus area will be removed from future annual review activity.						

Contract Area: Grievances (Onsite Review)	FM	SM	PM	MM	NM	NA
Attachment D, 5.5.3 Additional Requirements for CONTRACTOR(S) Member and Provider Grievance, Appeal, and State Fair Hearings and Provider Reconsideration Tracking and Staff Training **Attachment D, 5.5.3.1** The tracking systems for Member Grievances (4.2.1), Member Appeals (4.4.2.1), Member State Fair Hearings (4.6.2.1), Provider Grievances (5.2.1), Provider Reconsiderations (5.4.2.1), Provider Appeals (5.4.7.1), and Provider State Fair Hearings (5.5.2.1) must have functionality to create database extract files or other files, as determined by the State, that can be imported into the State's Grievance, Reconsideration, Appeal and State Fair Hearing database or other reporting software. **Attachment D, 4.2.1.8** The CONTRACTOR(S) shall resolve 98% of Grievances and provide a Notice of Member Grievance Resolution as specified in this Attachment within thirty (30) calendar days from the date the Grievance is received. If the Member's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this period. If the Member's request was made in writing, the date of receipt of the written request shall be used as the start of this resolution period.						

Onsite Review Comments: Member Grievances, Appeals and State Fair Hearings: • Member grievances, appeals and state fair hearings are stored in ETS. All the GAR reporting comes from ETS. • The compliance requirements are entered into ETS, which calculates due dates for acknowledgement letters and resolution notices. Member Grievances and Appeals: • All of the different areas have different queues they work. If a staff member is working member cases only, United can set up their specific queue to only pull member cases. • The integrated letter program that produces all of United's A&G letters/notices is tied into ETS. The letter program can pull all of the member information needed for the letter/notice from the ETS system. • When a case is forwarded to the clinical team, they review the case and enter their case comments into ETS. The explanation/rationale for the decision is not automatically populated in the letters/notices, but the resolving analyst can copy and paste the information into the letter/notice. • All grievances, appeals and state fair hearings received by customer service, account management, or the online portal go through United's triage/data entry department. That department enters those cases and route into separate queues. • They go to the resolving analyst for review and acknowledgement letters are sent. If it has to be reviewed by the clinical team, this is when it is sent. United may pend the case if they need to send it to another area requesting additional information. • Once the analyst has all the needed information, it comes back to the grievance and appeal team in ETS. They send the resolution notice. • United attaches the letters for reviewing and the case is closed. All notices are attached to each case. • When United receives a request for an appeal for a denial of a prior authorization, they review the authorization to see if it was denied. If the provider did not provide any supporting documentation, the A&G team will request that information prior to forwarding the appeal request to the clinical team. The clinical team determines if there is enough information or if they need additional information. • The initial denial is determined by the specialty team, not the A&G team. • The triage team determines the category for grievances and appeals. • United monitors grievance/appeal trends proactively and work with provider education tools to address trends.						

• A&G analysts can access notices of action and adverse benefit determination. It's a manual process to determine if appeal was submitted timely. • ETS does not include complaints received through the State's MCO managers. • ETS has designated field that can show related appeals if both member and provider appeal decision. • ETS does not have the date of the initial notice. Not tied to that system that produces initial notices. Analyst can enter it manually. • It is the A&G analyst identifying the grievance or appeal category and that information is what populates the GAR.						

Contract Area: Grievances (Desk Review)	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
4.2.1.4 The CONTRACTOR(S) shall acknowledge each oral or written Grievance received from a Member or their Authorized Representative in writing within ten (10) calendar days of receipt. For Grievances resolved the same day of receipt, the CONTRACTOR(S) is not required to issue an acknowledgement but shall acknowledge receipt of the Grievance in the Notice of Member Grievance Resolution. The CONTRACTOR(S) shall acknowledge 100% of Grievances within ten (10) calendar days from the date the Grievance is received.	**X**					
Documentation for 4.2.1.4 Acknowledgement of Grievances						
Desk Review Comments: All 15-member grievance acknowledgement letters were mailed within the ten (10) calendar day requirement. Grievance Policy – No corrections needed.						

Contract Area: Appeals (Onsite Review)	FM	SM	PM	MM	NM	NA
Attachment D, Section 1.1.1 The CONTRACTOR(S) shall develop, implement, and maintain a Member Grievance and Appeal System that complies with the requirements in applicable Federal and State laws and regulations including, but not limited to, the Code of Federal Regulations (CFR) at 42 CFR § 431.200, 42 CFR Part 438, Subpart F, "Grievance and Appeal System," Kansas Statutes Annotated (K.S.A.) 77-501 et seq., "Kansas Administrative Procedures Act" (KAPA), Kansas Administrative Regulations (K.A.R.), and applicable provisions of Kansas Statute 40-3228 relating to Grievance procedures. **Att. D, Section 4.4.2.1** The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting and resolving Appeals by Members or their Authorized Representatives through the Appeal process administered by the CONTRACTOR(S) or a Subcontractor(s). **Att. D, Section 4.4.2.1.9** The CONTRACTOR(S) shall resolve 100% of Appeals within thirty (30) calendar days of the date the CONTRACTOR(S) receives the earliest request for an Appeal from the Member, unless it is an Appeal requiring expedited resolution, and provide Notice of Appeal Resolution of the CONTRACTOR(S)' decision. If the Member's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this resolution period. If the Member's request was made in writing, the date of receipt of the written request shall be used as the start of this resolution period.						
Documentation for Att. D, Section 1.1.1. G&A System; 4.4.2.1. P&P; 4.4.2.1.9. Standards						
Onsite Review Comments: See comments above in Grievances section.						

Contract Area: Member Appeals (Desk Review Only)	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
Attachment D **4.4.2.1.5** The CONTRACTOR(S) shall acknowledge each oral or written Appeal received from a Member or their Authorized Representative in writing within five (5) calendar days of the earliest request for an Appeal. If the Member's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this period. If the Member's request was made in writing, the date of receipt of the written request shall be used as the start of this period. The CONTRACTOR(S), in its acknowledgement, may request the Member to sign a written Appeal form if the original request was made orally or telephonically. A Member's refusal or failure to return a written or signed Appeal form cannot be used as a basis for the CONTRACTOR(S)' refusal to process the Appeal. For Expedited Appeal Requests, the CONTRACTOR(S) is not required to issue an acknowledgement but shall acknowledge receipt of the expedited Appeal request in the Notice of Expedited Appeal Resolution. The CONTRACTOR(S) shall acknowledge 100% of Appeals within five (5) calendar days from the date the Appeal is received;	**X**					
Documentation for 4.4.2.1.5 Member Appeals						
Desk Review Comments: All 5-member appeal acknowledgement letters were mailed within the five (5) calendar day requirement.						

Contract Area: Cultural Competency	FM	SM	PM	MM	NM	NA
5.5.4.A The CONTRACTOR shall: **5.5.4.A.1** Promote and participate in the State's efforts to ensure that Covered Services are delivered in a culturally competent manner to all Members and is responsive to Members' health literacy needs, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity;	X					
5.5.4.A.4 Incorporate in its policies, administration, and service practice the values of (i) honoring Members' beliefs, (ii) sensitivity to cultural diversity, and (iii) fostering in staff and Providers' attitudes and interpersonal communication styles which respect Members' cultural backgrounds. The CONTRACTOR(S) shall have specific policy statements on these topics and communicate them to Subcontractors and Participating Providers; and	X					
5.5.4.A.5 Foster and enhance Participating Providers' understanding and application of techniques to identify and adapt to Members' cultural preferences and health literacy needs as an integrated component of service delivery.	X					
5.5.4.B Cultural Competency Plan: Within 90 days of award, the CONTRACTOR(S) shall develop and submit for State approval a Cultural Competency Plan. The Cultural Competency Plan shall be evaluated, updated, and submitted annually to the State. The Cultural Competency Plan shall include, but not be limited to: **5.5.4.B.1** Description of how care and services are delivered in a culturally competent manner, including how this will be achieved in rural areas of the State via telehealth strategies;	X					
5.5.4.B.2 Role of Social Determinants of Health and Independence in improving and sustaining positive health Outcomes;	X					
5.5.4.B.3 Strategies to assess and respond to the health literacy needs of Members;	X					
5.5.4.B.4 Identification of the CONTRACTOR(S)' specific staff responsible for the development and maintenance of the Cultural Competency Plan;	X					
5.5.4.B.5 Goals for the coming year;	X					
5.5.4.B.6 Training and education methods utilized by the CONTRACTOR(S) to educate staff, Participating Providers, and Members about cultural competency, including a description of the training programs; and	X					
5.5.4.B.7 Description of how the CONTRACTOR(S) conducts regular assessments of the Provider network to ensure services are provided in a culturally competent manner to diverse populations.	X					
Documentation for 5.5.4. Cultural Competency; 5.5.4.A and 5.5.4.B; and related subsections:						

(continued) Contract Area: Cultural Competency	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
Desk Review Comments: Reviewer appreciates the manner in which all contract items were identified in the appropriate documentation. **Sharon Johnson**						
Onsite Review Comments: All requested documentation was provided.						

Contract Area: Local Education Agencies	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.1.5 Cooperation with Other State Agencies **5.1.5.D** Local Education Agencies: CONTRACTOR(S) is required to cooperate with these Local Education Agencies for the provision of Covered Services. The State will be monitoring this cooperation in order to assess possible future CONTRACT requirements.	**X**					
Documentation for 5.1.5.; and 5.1.5.D Cooperation with Other State Agencies:						
Desk Review Comments: Everything looks great. United submitted everything that was requested.						

Contract Area: MCO Participant Advisory	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.10.12 Member Rights and Protections **5.10.12.D** MCO Member Advisory Committees-CONTRACTOR(S) will maintain a mechanism to gain Member input into their process and system of care. CONTRACTOR(S) shall create and maintain a Member Advisory Committee(s), which must be representative of the Membership being served, including LTSS and Behavioral Health Members. **5.10.12.D.4** Quarterly, the CONTRACTOR(S) shall submit a written report to KDHE-DHCF. The report shall contain information about meeting(s) held in the past quarter, how the CONTRACTOR(S) is addressing previous issues raised by the Member Advisory Committee, and who attended meetings. The CONTRACTOR(S) shall designate an employee to present this report and answer related questions to groups as identified by KDHE-DHCF.	**X**					
Documentation for 5.10.12.D Member Rights and Protections; and 5.10.12.D.4 Reporting						
Desk Review Comments: All requested materials were provided.						

Contract Area: Member Handbook and Notification (Generally) Submission and Reporting Requirements	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.10.2.B.1 Advance Directives Changes in State law must be provided as soon as possible, but no later than ninety (90) days after the effective date of the change in State law. Applicable State Law of Kansas may be found in K.S.A. the Kansas Natural Death Act, K.S.A. 65–28,101 et seq. and the Kansas Durable Power of Attorney for Health Care Decisions, K.S.A. 58–625 et seq. **5.10.7.E The content of the Member Handbook must include the following:** **5.10.7.E.1** A Table of Contents. **5.10.7.E.2** A glossary, where all CONTRACTOR(S) will use the State definitions for managed care terminology, including the terminology specified at 42 CFR § 438.10(c)(4)(i).	X					
5.10.7.E.4 Appointment procedures.	X					
5.10.7.E.6 A description of all available Covered Services, any Value-Added Benefits, an explanation of any service limitations, or exclusions from coverage and a notice stating that the CONTRACTOR(S) will be liable only for those services authorized by the CONTRACTOR(S).	X					
5.10.7.E.7 What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency, including how to access the CONTRACTOR(S)' twenty-four (24) hour toll-free number. Information should also distinguish between an emergency using the prudent layperson standard, emergent care, and Urgent Care. In a life-threatening situation, the Member Handbook should instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 9-1-1. The CONTRACTOR(S) shall not require the Member to call the CONTRACTOR(S) or PCP prior to going to the Emergency Room for Prior Authorization in accordance with section 1932(b)(2) of the SSA. **5.10.7.E.9** How to obtain emergency transportation and medically necessary transportation. **5.10.7.E.10** How to obtain behavioral health services.	X					
5.10.7.E.12 Information regarding out-of-county and out-of-state moves	X					
5.10.7.E.13 Informing the Member that if he or she has a worker's compensation claim, or a pending personal injury or medical malpractice law suit, or has been involved in an auto accident, to immediately contact the KHPA-DHCF Medicaid Unit, Third Party Liability (TPL) Manager.	X					
5.10.7.E.14 Contributions the Member can make toward his or her own health, Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CONTRACTOR or the State.	X					

(continued) Contract Area: Member Handbook and Notification (Generally) Submission and Reporting Requirements	FM	SM	PM	MM	NM	NA
5.10.7.E.20 Member rights and responsibilities, including the elements specified in 42 CFR § 438.100.	X					
5.10.7.E.21 The process of selecting and changing the Member's PCP. Member's rights to change Providers or disenroll for cause.	X					
5.10.7.E.22 Grievance, Reconsideration, Appeal, and State Fair Hearing procedures and timeframes, consistent with 42 CFR § 438 subpart F, in a State-developed or State approved description. **5.10.7.E.24** The toll-free telephone number for Member services, medical management, and any other unit providing services directly to Members. **5.10.11 Member Crisis Assistance** **5.10.11.A** The CONTRACTOR(S) must operate a toll-free phone number twenty-four (24) hours a day/365 days a year to respond to Members needing immediate assistance. **5.10.11.B** The toll-free number must be published in the Member Handbook, the Member ID card and associated materials. The services of this Help Line shall include: **5.10.11.B.1** Telephone crisis intervention.	X					
5.10.11.B.2 Risk assessment.	X					
5.10.11.B.3 Referral and consultation to callers which may include caregivers, family members and other community agencies seeking assistance with Behavioral Health issues.	X					
5.10.11.B.4 Kansas-specific information of community resources such as contact information to the Member's local Regional Alcohol and Drug Assessment Center (RADAC), Social Detoxification unit, Certified Gambling Counselor or Mental Health Center shall be provided.	X					
Documentation for 5.10 Member Handbook and Notification; and all related sub-sections; Submission and Reporting Requirements subsections:						
Desk Review Comments: No comments. Requirements fully met.						

Contract Area: Attestations - Subcontractors	FM	SM	PM	MM	NM	NA
5.5.13 Delegation Relationships If any of the CONTRACTOR(S)' activities or obligations under this CONTRACT are delegated to a Subcontractor, the CONTRACTOR(S) shall: **5.5.13.A** Maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its CONTRACT with KDHE-DHCF. **5.5.13.B** Ensure the terms of Subcontracts are subject to the applicable material terms and conditions of the CONTRACT existing between the CONTRACTOR(S) and KDHE-DHCF for the provision of Covered Services. **5.5.13.C** Evaluate a prospective Subcontractor's ability to perform duties to be delegated. **5.5.13.D** Ensure that delegated activities or obligations and related reporting responsibilities are specified in the Subcontract and that the Subcontractor agrees to perform the delegated activities and reporting responsibilities as specified in compliance with the CONTRACTOR'S obligations under this CONTRACT. All Subcontracts must contain full disclosure of all terms and conditions, including disclosure of all financial or other requested information.					X	
Documentation for 5.5.13 Delegation Relationships; and related sub-requirements:						
Desk Review Comments: No documents for desk review were submitted.						
Onsite Review Comments:						

Contract Area: Participant Direction	FM	SM	PM	MM	NM	NA
5.4.10 Service Coordination Training Requirements **5.4.10** The CONTRACTOR(S) shall develop a comprehensive onboarding and training program to be completed within the first ten (10) days of employment for all Service Coordination and contracted community Service Coordination staff that has the following components: **5.4.10.A** A dedicated staff trainer who ensures that all training requirements are met. **5.4.10.B** A detailed Service Coordination training plan describing how the CONTRACTOR(S) will meet the initial, annual, and ongoing training requirements. **5.4.10.C** An initial training curriculum that at a minimum includes: **5.4.10.C.1** The CONTRACTOR(S)' model of care; 2. Cultural competency; 3. PCSP and Plan of Service, as appropriate; 4. Grievances and Appeals reporting, processes, and procedures; 5. Availability of community resources in the service coordinator's respective geographic areas; 6. Care Management strategies for disease specific processes; 7. Abuse/neglect/exploitation recognition and mandated reporter requirements, and reporting requirements and use of the State's Adverse Incident Reporting (AIR) system; 8. HIPAA; 9. Clinical assessment and documentation; 10. Interviewing, asking appropriate questions; 11. Medication monitoring; 12. Members' rights and responsibilities; 13. Medicaid Fraud; 14. Trauma informed care; 15. Social Determinants of Health and Independence; 16. Advance Directives and legal designations (guardian, power of attorney, representative payee, etc.); 17. K.A.R. 30-63-1 through 30-63-32 addressing training requirements for the IDD populations **5.4.10.D** An annual training curriculum that includes at a minimum: **5.4.10.D.1** Cultural competency; 2. Person-centered service planning; 3. Grievance and Appeals reporting, processes, and procedures; 4. Abuse/neglect/exploitation recognition, mandated reporter requirements, and associated reporting requirements; 5. HIPAA; 6. Medicaid Fraud; 7. Trauma informed care; 8. Social Determinants of Health and Independence **5.4.10.E** The CONTRACTOR(S) shall conduct an ongoing evaluation of the success of training and assessment for the need for additional training.						
Documentation for 5.4.10 Service Coordination Training Requirements; and related sub-sections: No desk review comments submitted as of April 24, 2020.						
Desk Review Comments: No onsite review conducted for 2019.						

Contract Area: Pharmacy Providers and Utilization	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
MCOs Contract, page 6, Section X. Pharmacy letters g. "Pharmacy Reimbursement" and h. "Maximum Allowable Cost List Administration."						
Documentation for Att. C, 2.7 Prescription Drugs; Pharmacy letters; Pharmacy Reimbursement; Maximum Allowable Cost List Administration; and sub-related requirements;						
Desk Review Comments: MAC List: United's MAC list was according to state policy	X					
Desk Review Comments: Pharmacy Reimbursement: Please resubmit information using the example given. Please have examples from all four "lesser of" categories.			X			

Contract Area: Provider Network **(Crisis Responsiveness to MH Services)**	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.5.7.E.4 The CONTRACTOR(S) shall develop and maintain a comprehensive Behavioral Health crisis response network that shall include: **5.5.7.E.4.a** Crisis responsiveness which includes twenty (24) hours a day, seven (7) days a week, 365 days a year emergency treatment and first response, including, when appropriate, staff going to the Member for personal intervention and for any Member that staff become aware of experiencing a crisis or other emergency. **5.5.7.E.4.b** Provision of or referral to psychiatric and other community services, when appropriate. **5.5.7.E.4.c** Assessment of any Member experiencing a Behavioral Health crisis to determine the need for inpatient, treatment, crisis services, or other community treatment services. **5.5.7.E.4.d** Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services. **5.5.7.E.4.e** Follow up with any Member seen for or provided with any emergency service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution.			**X**			

Documentation for 5.5.7.E Behavioral Health Provider Network Standards; and related sub-requirements Crisis Responsiveness to BH Services:

Onsite Comments:
#1 remains pending with KDADS

#2 documentation of compliance with 5.5.7.E.4 d & e remain outstanding. Requested procedure which includes these required activities.

#3 list of current contracted BH crisis response providers and the county they are contracted to serve has not been received. This item remains outstanding.

#4 remains pending with KDADS

Post Onsite Desk Review Comment: 2.14.2020 post onsite desk review comments:

#2: received and reviewed Kansas Addendum to Management of Behavioral Health Benefits policy. Policy is a copy/paste of the contract. Requested procedure: who, what, when, where, etc. remains outstanding

#3: plan submitted a map of the CMHCs in KS & the counties they serve. This leaves the State to assume that each CMHC is contracted with UHC to provide 24/7-365 treatment and first response for any BH crisis which occurs in the county they serve, and the contracts contain/require all the elements in 5.5.7.E.4.a-e.

Contract Area: Claims	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.14 Claims Management **5.14.1.A-K** Timely Claims Processing and **Attachment I:** KanCare Claims Processing Requirements						
Note-Business Operations Team (BOT) is completing an independent annual review; outcomes will be combined with master review documents for a final report in Q12020.						
Desk Review Comments: No comments submitted as of April 24, 2020. Comments will be added upon completion of the BOT review.						

Contract Area: Utilization Management (UM) Activities	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.8.1.D 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. **5.8.2.A** The CONTRACTOR(S) shall monitor and evaluate on an ongoing basis the appropriateness of care and services. The evaluation shall be a fluid document that is updated as UM services are evaluated on a monthly, quarterly, semi-annually and annual basis. The UM Plan and evaluation results must be submitted at least annually to the State for review. **5.8.3.E.3** The CONTRACTOR(S) shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with requesting Providers when appropriate. **5.8.2.A.1** Identify and describe the mechanisms to detect services that are the drivers of utilization costs and the services that are identified as being underutilized. **5.8.3.E.5.c** The policies, procedures and practice guidelines shall be: **5.8.3.E.5** Based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; **5.8.3.E.5.b** Consider the needs of the Members; and, **5.8.3.E.5.c** Adopted in consultation with contracting health care professionals and reviewed and updated periodically as appropriate. **5.9.1.E** The CONTRACTOR(S) shall develop and implement mechanisms to detect both underutilization and overutilization of services **5.12.2** CONTRACTOR(S) shall notify the State of Members suspected of participating in fraudulent or abusive activities. Notification must be in written format with supporting documentation attached. The Members may be identified through UM, chart review, or by referral from Participating Providers. **5.8.1.D** 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.	X					
Documentation for 5.8 Utilization Management; 5.9 General Requirement; and 5.12 Program Integrity						
Onsite Review Comments: None submitted as of April 24, 2020.						

Contract Area: Network Adequacy: Network Management	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.5.8.A Establish procedures to ensure that network Providers comply with all timely access requirements as defined by the State and specified in Sections 5.5.5, 5.5.6, and 5.5.7, and provide documentation demonstrating monitoring efforts. As network access issues arise, the CONTRACTOR(S) shall report areas of network deficiency within twenty-four (24) hours and a plan for resolution to the State within five (5) business days. Report must be made to the State Medicaid Agency and the State Operating Agency as applicable. **5.5.8.D** Continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, Member grievances and appeals, quality data, quality improvement data, eligibility, utilization of services, penetration rates, Member satisfaction surveys, and demographic data requirements.			X			
Documentation for 5.5.8.A Access Requirements; and 5.5.8.D Monitoring Adequacy						
Desk Review Comments: 5.5.8.A: A total of 10 documents were submitted by UHC for this contract area. Each document is underlined with review following: Network Management Narrative READ FIRST was used in guiding the review #1 (5.5.8.A) Policy submitted "Assessing Member Experience" first sentence states this policy applies to Commercial & Marketplace products so stopped reading. Policy submitted "Accessibility of Services" was reviewed. This is a high level, corporate policy. No KanCare specific requirements are incorporated. Does say that access standards will be reviewed annually. Says to refer to the applicable annual report for the selected standards, goals and thresholds. Does not mention what actions occur if a provider needs correction—says they "identify opportunities"—not really the same thing. 2017 Annual Appointment Waiting Times Report submitted and reviewed. This is for the previous contract period. But, does show the Kansas access standards. Still does not show what steps UHC takes with providers found not in compliance.						

(cont'd) Contract Area: Network Adequacy: Network Management	FM	SM	PM	MM	NM	NA
Dial America Guidelines submitted and reviewed. These guidelines should be mentioned as part of the UHC/KanCare policy. For example, one step in the procedure would be: UHC will submit to Dial America the parameters for the required practitioner types to be reviewed. Policy should state who and when and how often. Some of the guidelines don't apply to KanCare: Appointment availability calls for specialists should include asking, "If I were a UHCCP member": Unclear if this process occurs at the local (KS) level or is done by Dial America In reviewing the 2017 annual report—doesn't appear that the local plan gets any of the non-compliant actions. Outdated version of the Accessibility of Services policy seems to be attached to the end of the guidelines—did not review this. C&S Telephonic Office Site Survey: Recommended Process of Appointment Access submitted and reviewed. Could not discern what C&S stands for. This is a document of recommendations for what States may or may not want to do. Is not a UHC KanCare established procedure. #1: MCO needs to establish and submit a procedure which summarizes all the steps taken for ensuring the UHC KanCare providers are complying with all timely access requirements, (5.5.5, 5.5.6, 5.5.7). Procedure must also include the requirement to document efforts, address access issues which arise, process to take corrective action when providers fail to comply and reporting areas of deficiency along with resolution plan. A procedure which pulls all the pieces together and is specific to KanCare 2.0. Onsite: demonstrate KanCare specific documentation and analysis tools i.e., call script, corrective action taken with a provider—how need for correction was identified & steps taken to correct. **Sheri Jurad**						
Onsite Review Comments: Dashboard of results of the 2019 timely access review done by contractor Dial America was shown overhead. This has not been shared with the State review team. Plan reports results are discussed in Quality Management committee. Held discussion regarding the steps taken when/if a provider is not in compliance with the standards. For example, vendor found, in 2018, 50 percent of EPSDT providers were out of compliance with access standards and then in 2019 back to 100% compliance. MCO reports no follow up is done. Those providers not in compliance have no follow up and are not required to be included in any follow up study. Plan reported they do not feel a formal process is necessary. MCO mentioned internal guidelines exist for Dial America but these were not provided to the State review team to ensure KanCare contract requirements are included. Plan reported in 2018 there may have been a disparity in the interpretation of the requirements by the Dial America staff from the UHC and State contract requirements.						

(cont'd) Contract Area: Network Adequacy: Network Management	FM	SM	PM	MM	NM	NA
MCO mentioned internal guidelines exist for Dial America but these were not provided to the State review team to ensure KanCare contract requirements are included. Plan reported in 2018 there may have been a disparity in the interpretation of the requirements by the Dial America staff from the UHC and State contract requirements. MCO reports they do not have a formal corrective action process. MCO reports they do no individual follow up and do not receive the names of the individual providers who were out of compliance from vendor, report no proactive steps are taken, either. 2019 Dial America results and the KanCare tools used by the vendor (i.e. call script & desk procedure) remain outstanding. Formal process for identifying the need for correction and steps taken to correct non-compliance needs to be developed and submitted. Dial America's practice to exclude providers who are unreachable, no longer in practice and provide BH services is not compliant with this contract or Parity. If a member is trying to reach a provider for medically necessary services and that provider is unresponsive, uncooperative or no longer in business this provider is not compliant with access standards (5.5.5.1.A. & 5.3.1.B.). Dial America should be sending UHC provider level data regarding results so that UHC can implement a corrective action and follow up.						
Post-Onsite Desk Review Comments: Documents received and reviewed. UHC Dial America Guidelines- shows 24/7 accessibility req's. only applies to pcps; follow-up process for non-compliant practitioners is spelled out and seems to show practitioner level corrections are made, however staff at UHC report this process is not followed. They report they do not receive provider level information from DialAmerica so they wouldn't know who to make corrections with.						

(cont'd) Contract Area: Network Adequacy: Network Management	FM	SM	PM	MM	NM	NA
Call scripts show that the callers identify themselves as calling "on behalf of UHC community plan" this is different than what the plan staff reported at the site visit. They reported at the site visit that the calls were truly blind calls (acting as if they were UHC members). Call scripts after hours again shows only used with PCPs-this is contrary to the 2019 annual report. does show the unacceptable responses Call script: BH shows they ask for appt with a dr times; doesn't really match our standards (5.5.7.D & E) Call script: OB don't see that State has trimester-based standards Call script: PCP Accessibility went back to the Dial America Guidelines—couldn't tell what an acceptable answer would be to the EPSDT & adult routine physical appointment questions would be Call script: specialist looks okay (except aren't checking for after-hours coverage) Accessibility of Services policy-same info as in the guidelines. This is a national policy-not Kancare specific 2019 annual report—this was also reviewed above in green. there is a table, in this report, with the KanCare specific standards. it does say, in the report, that physical/preventive appointment standard is 21 days (3 weeks) For SUD providers, pregnant and PWID access standards are not called out For MH providers, urgent, non-emergency standard is not called out Table 4 shows EPSDT and BH average, routine waits exceed the UHC standard, yet table 3A shows 100% compliance. The average wait time in 2019 for an EPSDT appointment was 39days. Overall, the UHC access standard policy, practice and procedures are not in alignment. There are discrepancies in the data reporting. The standards are not in complete compliance with the contract. Not all required providers are included in reviewing compliance. And, the plan reports they make no effort to correct access issues with providers.						

(cont'd) Contract Area: Network Adequacy: Network Management	FM	SM	PM	MM	NM	NA
3/2/20 desk audit: plan submitted on 2/21/20 the 2019 annual report again. This has already been submitted and reviewed above. The 2018 annual report was also submitted—these results are included in the 2019 report and are not needed. The 3rd 2/21/20 document is an Optum Behavioral Solutions of California document. This document was submitted twice. #2 (**5.5.8.D)** Member and Provider Surveys, Feedback Utilization Review and Monitoring submitted and reviewed. States the PAC, Provider Advisory Committee, uses survey results in "evaluating and monitoring the quality, continuity, accessibility, availability, utilization, and cost of the medical care rendered within the network." Optum BH Network Development Plan submitted. This would apply to BH only. Appears Optum depends on the member to notify Optum & identify network sufficiency and capacity issues. This point, in the policy, could be elaborated on to meet 5.5.8.D.'s requirements: *NS conducts network development/enhancement activities in areas where there are members without appropriate access to Optum network providers.* UHN Network Development and Retention submitted and reviewed. This policy has been updated since readiness (9/1/2019) to include the Kansas UHC Network Services team conducting network assessments to include all elements required in 5.5.8.D. #2 is met. Onsite: demonstrate an example situation when the Health Network Services team, through their assessment of the KanCare network found a quality or access issue that was presented to the Quality Management Committee. Describe how the issue was discovered, what the issue was and outcome.						

Contract Area: Network Adequacy: LTSS Provider Network Standards	FM	SM	PM	MM	NM	NA
5.5.6.G Ensure that all licensed and Medicaid-certified NFs will be offered inclusion in the CONTRACTOR(S) Provider network. The CONTRACTOR(S) can evaluate each Provider's continued network enrollment based on the assessment of quality and performance Outcomes.				X		
Documentation for 5.5.6.G NF Inclusion in Network:						
Desk Review Comments: Listing provided by the plan did not include all the elements requested. FU onsite provide NF name, county location, reason contracting &/or credentialing has not been completed.						
Onsite Comments: Requested NF listing was not provided at onsite. This remains outstanding. As of deadline, no additional documentation submitted for this metric.						
Post-Onsite Desk Review Comments: No additional documentation was submitted for this metric.						

Contract Area: Network Adequacy: Behavioral Health Network Standards	FM	SM	PM	MM	NM	NA
5.5.7.B The availability of types of Behavioral Health programs will vary from area to area, but access problems may be especially acute in rural and frontier areas. The CONTRACTOR(S) shall establish a program of assertive outreach and telemedicine programming capabilities to all areas but especially to rural and frontier areas where Behavioral Health services may be less available than in more urban areas. The CONTRACTOR(S) shall monitor utilization in regions across the State to ensure access and availability of all Behavioral Health services in all regions.					X	
Documentation for 5.5.7.B Behavioral Health Services Outreach and Telemedicine						
Desk Review Comments: Received cover sheet but no policy was attached. FU onsite desk review session, need BH and telemedicine policy.						
Onsite Comments: The policy requested was not received at onsite. This remains outstanding.						
Post Onsite Desk Review Comment: Plan submitted the KMAP manual, and a brochure-type telehealth document. Does not meet requirement.						

Contract Area: Network Adequacy Delegation Relationships	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.5.13.L Each Subcontract, and, upon the request of the State, any further delegations by a Subcontractor, shall be subject to review and/or written approval by the State.					X	
Documentation for 5.5.13.L Subcontractors Approved by State						
Desk Review Comments: 5.5.13.L. Plan submitted a list of delegated subcontractors. Please clarify if Office Ally is a delegated subcontractor and if so, provide State approval of contract. All other delegated subcontractor contracts were approved by State. **Sheri Jurad** **Onsite Comments:** Did not provide verification of State approval of Office Ally subcontract at the onsite. This remains outstanding. **Sheri Jurad**						
Post Onsite Desk Review Comment: As of deadline, no additional documentation submitted for this metric.						

Contract Area: Network Adequacy Reports and Audits	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.16.1.B The CONTRACTOR(S) must take the following steps to ensure that data received from Participating Providers is accurate and complete: Verify the accuracy and timeliness of reported data; screen the data for completeness, logic and consistency; and collect utilization data in standardized formats as requested by the State.				X		
Documentation for 5.16.B Reports Accuracy						
Desk Review Comments: #1 reviewed policy: Provider Data Accuracy. This policy is sufficient to meet requirements for #1 but not for #2. Additional information is needed. Some level of clinical review needs to occur to verify that when a provider states they specialize in working with sexual abuse victims, for example, (see 5.5.2 G. 11 for more examples) that this information is accurate. Onsite: please demonstrate this process and how then these providers can be identified by members and the State. **Sheri Jurad**						
Onsite Desk Review Comments: MCO reports they have a policy/procedure for clinical verification of specialties, but this has not been provided to the State. Plan also reports member must call to request the providers referenced in 5.5.2.G.11. They do not list the specialties, verified by the plan, in the provider directory. Operationally, a member would have to call UHC and report to a stranger they have been sexually abused and are looking for a therapist who specializes in working with sexual abuse victims. In addition, the member's care team and the State do not have access to these specialty providers in the plans network. The specialties do not have to be listed using a provider specialty code. For example, the provider can be listed as a social worker in the member's zip code and the worker's page can list that they specialize in sexual trauma under Areas of Expertise, which is already an option in the UHC online provider directory.						

Contract Area: Members with a Service - Dental	FM	SM	PM	MM	NM	NA
5.4.2 Health Risk Assessment/Health Screens, **5.4.5** EPSDT Service Coordination, **5.5.4** Cultural Competency and Health Literacy in the Delivery of Care, and; **5.9.12** Clinical and Medical Records.			X			
Documentation for 5.4.2 HRAs; 5.4.5. EPSDT; 5.5.4 Cultural Competency; and 5.9.12 Medical Records as they pertain to Dental claims:						
Desk Review Comments: Eight of the ten records contained all records and x-rays. Two records did not include patient notes.						

Contract Area: Members with a Service - Vision	FM	SM	PM	MM	NM	NA
5.4.2 Health Risk Assessment/Health Screens, **5.4.5** EPSDT Service Coordination, **5.5.4** Cultural Competency and Health Literacy in the Delivery of Care, and; **5.9.12** Clinical and Medical Records.	X					
Documentation for 5.4.2 HRAs; 5.4.5. EPSDT; 5.5.4 Cultural Competency; and 5.9.12 Medical Records as they pertain to Vision claims:						
Desk Review Comments: All requested records provided. (One record contained two patient records)						

Contract Area: Members with a Service – Pharmacy	FM	SM	PM	MM	NM	NA
5.4.2 Health Risk Assessment/Health Screens, **5.4.5** EPSDT Service Coordination, **5.5.4** Cultural Competency and Health Literacy in the Delivery of Care, and; **5.9.12** Clinical and Medical Records.	X					
Documentation for 5.4.2 HRAs; 5.4.5. EPSDT; 5.5.4 Cultural Competency; and 5.9.12 Medical Records as they pertain to Pharmacy claims:						
Desk Review Comments: UHC has a cultural competency plan. Additionally, past items I have reviewed have been appropriate regarding cultural awareness.						

Contract Area: Members with Sterilization Cases	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
KanCare 2.0, Attachment C **2.32.** The CONTRACTOR is required to provide freedom of choice for family planning and reproductive health services, which may be out of the CONTRACTOR's network. The CONTRACTOR is responsible for payment of these services. **2.32.2.** For family planning purposes, sterilization shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and must always be reported as family planning services, in accordance with mandated federal regulations 42 CFR 441.250-441.259. **2.32.3.** Sterilizations shall be provided in accordance with the Federally mandated guidelines and consent form. 2.32.3.1 The approved Sterilization consent form can be found on the KMAP website. **2.32.3.2** The form shall be available in English and Spanish, and the CONTRACTOR(S) shall provide assistance in completing the form when an alternative form of communication is necessary. **2.32.3.3** The CONTRACTOR(S) must assure that the Federal Sterilization Consent form required by CMS in 42.CFR § 441.250 - 441.259 is properly completed as described in the instructions and a copy of the Sterilization Consent form is obtained from the performing Provider before paying the service claim. The CONTRACTOR(S) must maintain a copy of the form in the event of audit. In the event of an audit the CONTRACTOR(S) will provide additional supporting documentation to ascertain compliance with Federal and State regulations. Such documentation may include admission history and physical, pre and post procedure notes, discharge summary, court records or orders. **2.32.3.4** Hysterectomies are covered when the requirements, stated in the State Provider Manuals, State Policy and 42 CFR § 441.250-§ 441.259, are met.					X	

Documentation for Attachment C, 2.32 Sterilizations; and related sub-requirements:
Desk Review Comments: Provider did not ensure the proper consent form was signed. There was a review in which proper consent was not obtained. #15- The beneficiary was only 20 years old and no consent form was obtained and signed. What was reason this beneficiary was sterilized when she is under age 21? #7 - Hospital consent was used and not the federally required form.

Contract Area: Entities Providing a Lab Service	FM	SM	PM	MM	NM	NA
5.1.4.4. In accordance with CMS Release No. 35, Medicaid Clinical Laboratory Improvement Amendments (CLIA) Implementation, the CONTRACTOR shall obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Title XIX and Title XXI of the Social Security Act. The CONTRACTOR shall provide a listing to the State of all laboratories and/or entities providing laboratory services used by the CONTRACTOR and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. The CONTRACTOR shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.			X			
Documentation for 5.1.4.4 CLIA Certificates:						
Desk Review Comments UCH submitted CLIA documents. They did not receive responses from four providers and this was documented in a narrative. UCH was able to secure 16 out of 20 CLIA certificates requested. Please ensure that all certificates are current.						

Contract Area: Expedited Member Appeals	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
KanCare 2.0, Attachment D **4.5.2.5.** After the CONTRACTOR(S) receives the Expedited Appeal Request, it shall resolve 100% of Expedited Appeals and notify the Member of the receipt of the Expedited Appeal Request and the outcome of the Expedited Appeal, as expeditiously as the Member's health condition requires and no later than 72 hours from the date the CONTRACTOR(S) receives the request. **4.5.2.6.** For an Expedited Appeal, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to fourteen (14) calendar days if the Member requests an extension or the CONTRACTOR(S) shows (to the satisfaction of the State, upon its request. When an expedited appeal is requested the member may not file a SFH concurrently.	**X**					
Documentation for Attachment D, 4.5.2.5. Expedited Appeals; and 4.5.2.6 Extensions						
Desk Review Comments: 9 out of 10 expedited member appeals were resolved and notice sent within 72 hours of receipt. Case #8 the expedited member appeal request was received on July 8th, a decision was made on July 12th, and the notice was sent on July 17th.						

Legend: FM=Fully Met; SM=Substantially Met; PM=Partially Met; MM=Minimally Met; NM=Not Met; NA=Not Applicable

Contract Area: General Network Access Standards	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.5.5.3. Specialty Care Standards CONTRACTOR(S) must adhere to the following requirements: **5.5.5.3.A.** Specialty Care and Urgent Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, rehabilitation services, etc.) shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care. **5.5.5.3.B.** Waiting times shall not exceed forty-five (45) minutes. **5.5.5.4. Emergency Care Standards** CONTRACTOR(S) must adhere to the following requirements: **5.5.5.4.A.** Emergency Care: All emergency care is immediate, at the nearest facility available, regardless of whether the Emergency Room (ER) is a Participating Provider. **5.5.5.4.B.** Emergency services must be available twenty-four (24) hours a day, seven (7) days a week. **5.5.7.D.6.** Persons who inject drugs must receive an assessment and shall be admitted to treatment no later than fourteen (14) calendar days after making the request for assessment. If no program has the capacity to admit the Member within the required timeframe, interim services shall be made available to the Member no later than forty-eight (48) hours after such request. Admission to treatment must not exceed 120 calendar days of the request for assessment.	X					
Documentation for 5.5.5.3 Specialty Care Standards; and related sub-section 5.5.7.D.6 SUD Timeline for Assessment and Treatment:						
Desk Review Comments:						

Contract Area: Member Handbook and Notification	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
5.10.5.H. A written notice of termination of a contracted Provider, within fifteen (15) calendar days from issuance of the termination notice, must be sent to each Member who received his or her Primary Care from, or was seen on a regular basis by, the terminated Provider.					X	
5.10.6.A.12. Notification to all Members, at the time of enrollment, of the Member's rights to change Providers or disenroll for cause.					X	
5.10.6.A.11. Notification to all Members of their right to request and obtain Member Handbook information at least once a year.					X	
5.10.1.C. The CONTRACTOR(S) shall provide Members with at least thirty (30) calendar days written notice of any significant change in policies concerning Members' disenrollment rights, right to change PCPs or any significant change to any of the items listed in Member Rights and Responsibilities regardless of whether the State or the CONTRACTOR(S) caused the change to take place.					X	

Documentation for 5.10.5.H Providers Terminated for Cause; 5.10.6.A.12 Member Notification; 5.10.6.A.11 Member Handbook; and 5.10.1.C Disenrollment Rights

Desk Review Comments: Screens showing system coding – flag with eff date noted in comments, but in the flag area, nothing with that date. We really only needed to see providers that received UHC letters. Most in this case list did not have letters. The following provider is not/has never been part of the KS Medicaid Network:

Jeffrey Hellinger

The following providers were Non-Par so no termination would have been sent. The requirement for this was in-network providers that were terminated for cause:

- Jeff Sloyer
- Kohlls Pharmacy
- Carepoint Medical/Damedix healthcare
- Foremost Labs
- KC Internal Medicine
- Confirmatix Laboratory
- Proove Medical Labs
- OPKO Ourlab LLC

Medicus Labs

Contract Area: Pharmacy Providers and Utilization - DME	FM	SM	PM	MM	NM	NA
5.5.2. Network Development **5.5.2.G.7.** Ensure in-State Members receive services from in-State Providers when available at competitive rates and levels of quality.	X					
Documentation for 5.5.2 Network Development; and 5.5.2.G.7 In-State DME:						
Desk Review Comments: DME List: Not aware of drugs allowed to be billed under the DME option, if they are not a Part-B drug. Was this drug a Part-B approved drug? What code was used? Drug-Injection, alpha 1-proteinase inhibitor (human) (Prolastin), not otherwise specified, 10 mg. 5.5.2 and 5.5.2G.7 are fully met.						

Contract Area: Pharmacy Providers and Utilization - Pharmacy	FM	SM	PM	MM	NM	NA
5.8.3.E.3. The CONTRACTOR(S) shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with requesting Providers when appropriate. **The State will review 10 (ten) cases.**			X			
Documentation for 5.8.3.E.3 Consistent Application of Criteria for Authorization Decisions:						

Desk Review Comments: Please see specific example comments below. Overall, UHC data sent but reveals that UHC process needs improvement. UCH needs to follow the state provided PA processes, documents, etc. We will follow-up again in next year's review**.**

Case 55628901: The adherence listed in the notes is not what the state uses for adherence.
Case 56361734: The doctor letter reads like a copy and paste of the patient letter. While I understand that the general information is the same, please change the wording in the letters, so that the message reads as if it is "for" the person meant to be. For example:This section below is in the doctor letter. *This medicine is given to patients who are at least 18 years of age or older. The facts given to us do not show that you are at least 18 years of age or older. Please speak with your doctor about your choices. This decision was made per the UnitedHealthcare Community Plan of Kansas Diclegis-Bonjesta Guideline.*
Case 56362720: From the form the provider filled out, it appears to be a new request. As such, the labs and AIMS would not be required. Seems to be confusion on whether it was supposed to be a renewal, based upon the UHC PA team's notes. But glad to see the PA forms are being used.
Case 56392721: Does the system check for two or more antipsychotics or is it relying on the provider's response? What if this is not the only provider for this patient? They might not know that another provider is prescribing for this patient. This is a safety issue and should not be left to the provider's answer. The PA reviewer needs to verify whether duplicate therapy is happening above the PA limits. It appears that the system is not checking for duplicate therapy from the claims data.
Case 56394923: It looks like the LPN signed the PA form. Since they are not the prescriber, communication should have been sent back to the provider that the PA must be signed by the prescriber and not an authorized agent.
PA 02: Initial information did not appear to have primary coverage, but the notes later implied patient had primary, so no PA required.
PA03: The Criteria/Resources used should always be the Medicaid criteria or Medicaid policies. (AMHMR, PDL, and/or Clinical PAs, etc.)
PA 05: See note above. Why was this not just an approval for six months based upon PA criteria and recommended requesting a renewal PA later? Split approval seems to be extra work. This could lead to misleading data. This is also confusing to the provider and to the patient/parents.
PA 06: Please note that Physician Administered Drugs do require the 24-hour PA TAT. This has been a policy update and is on the updated MCO PA reporting template. Also, example letters to the provider and to the patient should have been on each of these examples but were not. Many examples sent did not include the letters.
PA 07 and 08: Please provide and/or educate the provider on the appropriate PA forms to use, so that they do not need to send in tens of pages of documents. We have simplified our process, so the provider needs to be benefited by that as well.
PA 09: Why is the UHC PA being used/available for the provider to use? The RFP requires the MCOs to use the STATE PA criteria and STATE forms, and to link the state PA website to the MCO PA website link, so the provider will get only ONE version of the criteria and the forms. Also, once we have them using the forms and we approve/deny based upon the required information, all will go better for everyone. (Training the provider.) The T/F information is not acceptable. The PA criteria lists the specific drugs that are required as prerequisite drugs. But, it does appear that the patient had this treatment already (2018), so the renewal section of the correct PA form would be the focus for the provider, since this was a UHC patient starting in 2017.
PA 10: You might list all the reasons that a PA is denied on the provider notification as well. Such as appropriate pre-requisite drugs at migraine prevention doses. This was noted in that patient letter, but not in the provider letter.
PA 12: Please educate providers on the PA process. We provide 24 hr. TAT per CMS and expecting for UHC to approve while the patient is in the room is not the standard process, which they know it is not. Please, again, train the provider to use the PA forms and not send pages of chart notes. Please don't request chart notes unless the PA criteria requests and/or you cannot find the previous drug use mentioned, in the MCO data base or the provider did not give dates of service for the T/F drugs listed. Specific asks only.

Contract Area: Provider Appeals	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
Attachment D **5.4.7.1.5** The CONTRACTOR must send a letter to the provider within ten business days acknowledging receipt of the appeal request. **5.4.7.1.6** The CONTRACTOR(S) shall resolve 98% of Provider Appeals within thirty (30) calendar days of the date the CONTRACTOR(S) receives the Appeal request. **5.4.7.1.14** The CONTRACTOR(S) shall consider the Provider or Provider's Authorized Representative as a party to the Appeal. A Provider may seek a State Fair Hearing if the Provider is not satisfied with the CONTRACTOR(S)' decision in response to an Appeal. **The State will review 10 (ten) cases.**		X				
Documentation for 5.4.7.1.5 Acknowledgement Letter; 5.4.7.1.6 Appeals Resolution; 5.4.7.1.14 Right to State Fair Hearing:						

Desk Review Comments:
Desk review's case list findings were reviewed with United during the on-site G&A session. United responded in February 2020 with the following:

- Desk review Case #Z1750544002-UHC did not pay the correct rate as stated in this provider's SCA. Why wasn't it paid in full? Should have been paid at $1,600 per day.
  - *United researched this claim and determined that the claim was submitted and processed without the SCA. United corrected the error and will reimburse the provider according to the rate specified in the SCA.*
- Desk review Case #Z1761306007-retro eligibility? Was the initial denial based on a late filing? Claim was submitted late. Should it have been denied if it was a retro case?
  - *United researched this claim and determined there were no lapses in member's eligibility. Claim was submitted untimely and adverse decision upheld on appeal was appropriate.*

On-Site Comments:

Provider Grievances, Reconsiderations, Appeals, EITPR and State Fair Hearings:

- Provider grievances, EITPR, appeals and state fair hearings are stored in ETS.
- United relies on the provider to go to United's website to know what the criteria are for different services. United completes education through our provider advocate team. Every month United has their A&G review. If they see trends, they take a list of the providers and have the provider advocate team reach out to those providers.
- United sends all of the acknowledgement and resolution notices for grievances, reconsiderations and appeals.
- Erin Barrow updates and provides oversight for all of the notices for grievances, reconsideration and appeals.
- The claims system is integrated with ETS so analysts have access to the dates of provider remittance advices so United could provide length of time from date of initial remittance to resolution.
- United confirmed that many grievances are probably conveyed to provider representatives and placed in provider tracking reports, not G&A reports. Majority are claims issues. Provider reps help providers file reconsiderations. These need to go through a claims review. These don't get entered as formal provider grievances.

Reconsiderations:

- Reconsiderations are not stored in ETS. They are stored in a different system, MASIS.
- Tracked through the claims system.
- Appeal rights are included in the letter template within the claims tracking system. Analysts have access to this system and can track specific claims.
- United's Single Adjustment Team handles the entire reconsideration process. The A&G team has access to the system where reconsideration information is stored.
- United's reconsideration team sends out the acknowledgement and resolution notices for reconsiderations instead of the A&G team. United allows for a first reconsideration 120 days if it is the provider's error and 365 days if it is the MCO error from the date of service.
- A resolution notice is sent when they uphold their initial denial. If it is overturned the provider will receive a new PRA that shows the claim was paid instead of a resolution notice.
- Only a contracted provider may request a reconsideration. Non-par providers go directly to an appeal because they have to have a prior authorization before payment can be made they are not claim issues.

- United allows providers 120 days to file a reconsideration if it was their error and 365 days from the date of service to file one if it was United's error.
- United issues resolution notice if denial is upheld.
- United has a separate Reconsideration Team. Treated as a claims issue rather than as an appeal issue. Compliance is tracked by monthly claims review meetings. The Claims Team handles all of the reconsideration requests.
- The G&A team has some level of oversight of reconsiderations through the GAR process, but timeliness and trending is discussed by the Reconsideration Team in monthly meetings with Claims Team. They can determine timeliness based on date of notice. The date is manually entered.
- Appeals team has access to determine if provider has already filed a reconsideration.
- If providers don't specify what they're filing, automatically routed to Reconsideration Team.
- Reconsideration process is only for contracted providers.
- Non-contracted providers must have a PA, so not a claims issue. Appeals Team handles non-contracted providers.
- One person, Erin Barrow, has oversight over both reconsiderations and appeals to ensure notices are being sent timely, etc.
-

Auditing and Recoupments:

- United's Payment Integrity Team handles all of the auditing and recoupments. It is another system that feeds into United's claim system called ODAR. Analysts can see notes from this system.
- Med Review only issues initial determination notices.
- For appeals everything is sent to the A&G team and they send it to Med Review to review. Med Review sends the determination back to United. United issues the appeal notices.

State Fair Hearings:

- Filings for cases uploaded to ETS.
- United is prepared to track member and provider filing of hearings about same issue involved in EITPR.
-

5.4.7.1.5: Timeliness of the acknowledgement letters Standard is 100%. See Shirley's spreadsheet. UHC met that.

5.4.7.1.6: Timeliness of resolution within 30 calendar days. UHC met that. and timeliness of resolution. Standard is 98%. UHC met timeliness standard 8/10 times. UHC did not meet standard.

Contract Area: Provider Credentialing and Re-Credentialing and General Access Standards	FM	SM	PM	MM	NM	NA
5.5.6.G Ensure that all licensed and Medicaid-certified NFs will be offered inclusion in the CONTRACTOR(S) Provider network. The CONTRACTOR(S) can evaluate each Provider's continued network enrollment based on the assessment of quality and performance Outcomes. A CONTRACTOR(S) shall request approval from the State if it wants to terminate the CONTRACT of a NF for poor quality of care and not meeting performance Outcomes. The CONTRACTOR(S) must, in their request to the State, indicate the reasons for the termination, remedial actions that have been taken, preliminary plan on where residents would be transferred, impact of the transfers on the NF, and local community, and any other information that the CONTRACTOR(S) believe is relevant. Provider network agreements shall only be with NFs certified under Medicaid but CONTRACTOR(S) will be expected to help NFs move to both Medicare and Medicaid certification to maximize use of Medicare funding.						X
Documentation for 5.5.6.G LTSS Provider Network Standards:						
Desk Review Comments: None submitted. FOLLOWUP NEEDED **Onsite Review Comments:** No onsite review was conducted.						

Contract Area: Coordination and Continuity of Care for Members with a Service - Physical Health	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
Related to the BBA and State Contract areas: **5.4.2** Health Screening, Health Risk Assessments, and Needs Assessment; **5.4.3** Long-Term Services and Supports Functional Eligibility Determinations; **5.4.4** Plans of Service and Person-Centered Service Planning; **5.4.6** Managed Care Organization Service Coordination Roles and Responsibilities; **5.4.8** Qualifications for Service Coordinators; **5.9.1** General Requirements; **5.9.12** Clinical and Medical Records; **5.15.2** Use of and Safeguarding Data; **5.18** Work Program; and **5.27** Post-Contract Obligations and Procedures Cases will be reviewed in the order they appear on the sample list sent to the MCO. Please do not change the order when submitting records. KFMC will pull a sample of: • 20 cases for T19 • 20 cases for T21 **Only 15 cases each will be reviewed for T19 and T21**				X		
Documentation for 5.4.2, 3, 4, 6, and 8 Service Coordination; 5.9.1 General Requirements; 5.9.12 Clinical and Medical Records; 5.18 WORK Program; and 5.27 Post-Contract Obligations and Procedures:						
Desk Review Comments: This is partially met. Eighteen of the 30 records reviewed had either a health risk screen of an HRA completed. There is evidence of referrals and appropriate follow-up. The record review showed that UCH performed additional screens as necessary for triggers and/or conditions such as pregnancy to ensure members received necessary care.						

(cont'd) Contract Area: Coordination and Continuity of Care for Members with a Service - Physical Health	FM	SM	PM	MM	NM	NA
Post-Onsite Documents Review Comments:						

Contract Area: Coordination and Continuity of Care for Members with a Service - Behavioral Health	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
Related to the BBA and State Contract areas: **5.4.2** Health Screening, Health Risk Assessments, and Needs Assessment; **5.4.3** Long-Term Services and Supports Functional Eligibility Determinations; **5.4.4** Plans of Service and Person-Centered Service Planning; **5.4.6** Managed Care Organization Service Coordination Roles and Responsibilities; **5.4.8** Qualifications for Service Coordinators; **5.9.1** General Requirements; **5.9.12** Clinical and Medical Records; **5.15.2** Use of and Safeguarding Data; **5.18** Work Program; and **5.27** Post-Contract Obligations and Procedures Cases will be reviewed in the order they appear on the sample list sent to the MCO. Please do not change the order when submitting records. KFMC will pull a sample of: • 20 cases for T19 • 20 cases for T21 **Only 15 cases each will be reviewed for T19 and T21**	X					
Documentation for 5.4.2, 3, 4, 6, and 8 Service Coordination; 5.9.1 General Requirements; 5.9.12 Clinical and Medical Records; 5.18 WORK Program; and 5.27 Post-Contract Obligations and Procedures:						
Desk Review Comments: Case review verifies coordination and continuity of care for member with a service BH, processes are implemented as written. Sample files include health screenings, health risk assessments, and needs assessments, BH eligibility determinations, Plans of Service and PCSP when applicable; evidence of clinical/medical records and Work Program documentation is included in member file as necessary. Managed Care Organization for Service Coordination Roles and Responsibilities and Qualifications for Service Coordinators are confirmed through policy/procedure and position requirements are confirmed in position descriptions. Could not verify Post-Contract Obligations and Procedures through Desk Review, but interviews verify processes are in place.						

Contract Area: Coordination and Continuity of Care for Members with a Service - LTSS	FM	SM	PM	MM	NM	NA
Related to the BBA and State Contract areas: **5.4.2** Health Screening, Health Risk Assessments, and Needs Assessment; **5.4.3** Long-Term Services and Supports Functional Eligibility Determinations; **5.4.4** Plans of Service and Person-Centered Service Planning; **5.4.6** Managed Care Organization Service Coordination Roles and Responsibilities; **5.4.8** Qualifications for Service Coordinators; **5.9.1** General Requirements; **5.9.12** Clinical and Medical Records; **5.15.2** Use of and Safeguarding Data; **5.18** Work Program; and **5.27** Post-Contract Obligations and Procedures Cases will be reviewed in the order they appear on the sample list sent to the MCO. Please do not change the order when submitting records. KFMC will pull a sample of: • 20 cases for T19 • 20 cases for T21 **Only 15 cases each will be reviewed for T19 and T21**	X					
Documentation for 5.4.2, 3, 4, 6, and 8 Service Coordination; 5.9.1 General Requirements; 5.9.12 Clinical and Medical Records; 5.18 WORK Program; and 5.27 Post-Contract Obligations and Procedures:						
Desk Review Comments: Case review verifies coordination and continuity of care for member with a service LTSS, processes outlined above are implemented as written. Sample files include health screenings, health risk assessments, and needs assessments, LTSS Functional eligibility determinations, Plans of Service and PCSP when applicable; evidence of clinical/medical records and Work Program documentation. Managed Care Organization for Service Coordination Roles and Responsibilities and Qualifications for Service Coordinators are confirmed through policy/procedure and position requirements are confirmed in position descriptions. Could not verify Post-Contract Obligations and Procedures through Desk Review, but interviews verify processes are in place.						

Contract Area: Coordination and Continuity of Care for Members with a Service - SHCN	**FM**	**SM**	**PM**	**MM**	**NM**	**NA**
Related to the BBA and State Contract areas: **5.4.2** Health Screening, Health Risk Assessments, and Needs Assessment; **5.4.3** Long-Term Services and Supports Functional Eligibility Determinations; **5.4.4** Plans of Service and Person-Centered Service Planning; **5.4.6** Managed Care Organization Service Coordination Roles and Responsibilities; **5.4.8** Qualifications for Service Coordinators; **5.9.1** General Requirements; **5.9.12** Clinical and Medical Records; **5.15.2** Use of and Safeguarding Data; **5.18** Work Program; and **5.27** Post-Contract Obligations and Procedures Cases will be reviewed in the order they appear on the sample list sent to the MCO. Please do not change the order when submitting records. KFMC will pull a sample of: • 20 cases for T19 • 20 cases for T21 **Only 15 cases each will be reviewed for T19 and T21**						
Documentation for 5.4.2, 3, 4, 6, and 8 Service Coordination; 5.9.1 General Requirements; 5.9.12 Clinical and Medical Records; 5.18 WORK Program; and 5.27 Post-Contract Obligations and Procedures:						
Desk Review Comments: Still under review.						

<table>
<tr><td colspan="7">Naming Convention Instructions for Contract Area: Coordination and Continuity of Care for Members with a Service – PH, BH, LTSS, SHCN

(applicable to the four preceding reviews)</td></tr>
<tr><td>Related to the BBA and State Contract areas:
5.4.2 Health Screening, Health Risk Assessments, and Needs Assessment;
5.4.3 Long-Term Services and Supports Functional Eligibility Determinations;
5.4.4 Plans of Service and Person-Centered Service Planning;
5.4.6 Managed Care Organization Service Coordination Roles and Responsibilities;
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• 20 cases for T21
Only 15 cases each will be reviewed for T19 and T21</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="7">Case Lists were pulled by KFMC for the BBA audit. KDHE used those cases for the State review. Case files are located in KDHE ftp site folder 438.208, sub-folders Physical Health, Behavioral Health, LTSS, and SHCN.</td></tr>
</table>