IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program				
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - Addressed in the 2014 Anthem Blue Cross Blue Shield Kentucky Health Plan Quality Management Program Description (2014 QM PD). Assessing, monitoring, evaluating and improving the quality of care is addressed on pages 3-8, Introduction and Mission, Purpose, Quality Improvement (QI) Program Goals, Program Scope, Definition of Quality, and Objectives of the QI Program.	Full	Includes review of MCO Report #84 QAPI Program Description Addressed in the Kentucky Anthem Blue Cross & Blue Shield Medicaid 2015 Quality Management Program Description (2015 QM PD). Assessing, monitoring, evaluating and improving the quality of care is addressed on pages 3-8, Introduction, Mission, Purpose, Program Goals, Program Scope, Definition of Quality, and Objectives of the QM Program.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Full - Addressed in the 2014 QM PD. Processes that evaluate access to care, continuity of care, health care outcomes, and services are addressed on pages 3-6, Introduction and Mission, Purpose, QI Program Goals and Program Scope.	Full	Addressed in the 2015 QM PD. Processes that evaluate access to care, continuity of care, health care outcomes, and services are addressed on pages 3-8, Introduction, Mission, Purpose, Program Goals, Program Scope, and Objectives as well as Program Methodology and Key Program Initiatives, pages 9-18.	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - Addressed in the 2014 QM PD. Planned, systematic and clearly defined structures	Full	Addressed in the 2015 QM PD. Planned, systematic and clearly defined	

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	and processes are described on pages 3-8, Introduction and Mission, Purpose, QI Program Goals, Program Scope, Definition of Quality, and Objectives of the QI Program.		structures and processes are described on pages 3-8, Purpose, Program Goals, Program Scope, and Objectives as well as Program Methodology and Key Program Initiatives, pages 9-18 and throughout the QI Work Plan.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.	Minimal - Partially addressed in the 2014 QM PD, on pages 9-17, Program Methodology and pages 19 -20, QI Annual Evaluation. Since Anthem has been in operation for only 1 year, the MCO has not yet finalized a QI Program Evaluation, which is currently under development. In addition, the MCO cannot yet link findings from the regulatory compliance review, External Quality Review (EQR) Technical Report, accreditation survey, HEDIS® rates or CAHPS® survey since the MCO has been in operation only since January 2014. The MCO has not yet	Minimal	Addressed in the 2015 QM PD, on page 4, Program Goals; page 6, Program Scope; 9-17, Program Methodology and pages 9 - 12. Anthem prepared its first QI Evaluation for 2014. In 2014, the MCO had not yet reported HEDIS or CAHPS data, but the evaluation encompasses a wide variety of data sources, analysis, identification of opportunities, and planned actions. The following topics are addressed: member population assessment, patient safety, cultural competence, provider access and availability, including member satisfaction/complaints regarding access, access to customer service/call center data and access to behavioral health services, member experience, utilization review program and utilization of services, case and disease management, provider experience, clinical practice	A separate QMAC CAP addressing this requirement was submitted to DMS and accepted on 3/10/16.

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	completed some of these activities and is conducting other activities for the first time. However, the MCO does have some data from internal surveillance and monitoring, such as HRA timely completion rates, utilization data for (Emergency Department (ED), NICU, readmissions) and grievance trends. Anthem began monitoring HEDIS data in 2014. There was no evidence in committee minutes or the 2014 QM Work Plan of linking findings from the data that were available to improvement activities. For example, timely completion of HRA for pregnant women was reported as 0% in each quarter, yet there was no evidence of activities implemented to address this finding.		guidelines, continuity and coordination of care of medical care and between physical and behavioral health, delegation oversight and credentialing. For some of these topics, there are limited data since the MCO began operation in January 2014. Anthem evaluated access and availability from various perspectives, including GeoAccess, appointment availability for both physical and behavioral health, cultural competence, member complaints and grievances, and call center statistics. The MCO was able to identify and address issues related to members being billed for services, members having difficulty locating providers early in 2014, appeals related to pharmacy and outpatient services. There was evidence of discussion at the June Medical Advisory Committee (MAC) meeting; however, the meeting minutes did not reveal ongoing discussion of QI activities in process in 2015. This initiative was not documented in the QI Work Plan. Several of the random member grievance files reviewed onsite were related to members billed for services and members having difficulty identifying participating providers.	

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	As per quarterly Report #29, Anthem identified trends in grievances and proposed implementing member and provider education to address them, although specific interventions were not identified. There was no evidence provided that interventions had been undertaken to address these trends in 2014. The MCO evaluated ED utilization and implemented a Performance Improvement Project (PIP) to address this pursuant to DMS and IPRO recommendation. Evaluation of ED utilization revealed substantial utilization of the ED and a cohort of frequent ED utilizers. Committee minutes did not reveal evidence of linkage of findings for activities in process in 2014, although QI meetings relevant to the		Analysis of its Chronic Illness Intensity Index (CI 3) and readmission data revealed that there were a large number of members with COPD and that readmission for this condition was common and the MCO reported developing and implementing a plan of action, though there was no documentation of discussion in committees or information in the Work Plan. Onsite staff provided evidence of post-discharge case management follow-up for individual members with COPD. Anthem received its first External Quality Review (EQR) Technical Report in September 2015; however, it was limited to compliance review results due since the MCO is new to Kentucky Medicaid. The MCO received its final results and corrective action request for its first regulatory compliance review in late November 2015. The QI Work Plan includes the EQRO review as a task, but there is no update after March 2015 onsite audit. Anthem did submit responses to the preliminary findings. Discussion of the EQR review was not	

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	Kentucky MCO were limited. Anthem attended the monthly Quality Improvement Committee (QIC) corporate meetings. The Kentucky MCO was an agenda topic at one meeting for a status update, but QI findings were not discussed as per meeting minutes. The local Kentucky MCO Quality Management Committee (QMC) met only once in 2014 and QI findings were not discussed as per meeting minutes. **Recommendation for Anthem:** Anthem should conduct ongoing monitoring and surveillance of available data to identify opportunities for improvement, address findings in quality meetings, develop interventions to address barriers to appropriate processes, utilization and care and		found in committee minutes. Onsite staff indicated that findings were provided to project/program owners. Report #96 details the MCO's HEDIS reporting. Review and benchmarking of the HEDIS rates is documented in the QI Work Plan along with standard interventions. 2015 is the first year for HEDIS reporting. There is no evidence of discussion of analysis of HEDIS results and recommendations for improvement in committee minutes. The MCO is conducting PIPs focused on ED utilization and for Annual Dental Visits for children and adolescents. Report #94 details the MCO's CAHPS results. Anthem participated in a local MCO CAHPS workgroup to review results and share best practices. The July meeting minutes of the workgroup demonstrated discussion of the MCO's first CAHPS results. No discussion of CAHPS findings were found in the Kentucky MCO's committee meeting minutes. The Work Plan contains a Q2 update with goal rates but interventions are not evident. The MCO cannot yet link findings from	

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	monitor for improvement. **MCO Response:** Anthem is armed with HEDIS 2015 results, EQRO Compliance Review results, HRA results, G&A trends and will have CAHPS results in November 2015. With this comprehensive information additional quality activities will be taking place in 2015. In addition, this information and resulting activities will be introduced in QIC, QMC and MAC committees. **Final Review Determination:** No change in review determination. Anthem should ensure that the QI PD addresses linkage of QI projects to findings from multiple quality evaluations. Anthem should ensure that the MCO conducts and documents analysis of available data; presentation to and review of QI activities		accreditation survey since this has not yet occurred. The MCO is preparing for its first survey in June 2016. In general, committee review, analysis, of quality data and input on improvement initiatives was limited, based on the documentation submitted. There were no meetings of the Kentucky MCO Quality Management (QM) Committee in 2015, and therefore no minutes were submitted. Anthem Kentucky attended the corporate Quality Improvement Committee (QIC) meetings. The Kentucky MCO was an agenda topic at one meeting for a status update (Trilogy documents), but the specific Kentucky MCO QI activities and findings were not discussed as per meeting minutes Onsite staff confirmed that there were no QM committees meetings in 2015. Onsite staff indicated that the same staff that would have attended QM meetings attended the QIC meetings. Additionally, onsite staff indicated that data could not yet be trended due to initial MCO enrollment beginning in 2014.	

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	to by the committees; and linkage of QI activities to findings from multiple quality evaluations once the data and findings are available.		Other than the two PIPs and CAHPS workgroup, a corporate workgroup that Kentucky attended twice, there did not appear to be any initiatives to address findings submitted pre-onsite. It should be noted that the 2014 QI Evaluation contained extensive analysis of the member population characteristics and identification of some opportunities for quality improvement. However, these were not reflected in the QI Work Plan or the committee discussions. Onsite staff provided copies of emails to schedule conference calls to discuss follow-up of pharmacy appeals process issues (QM and UM), and a screen shot demonstrating processes to request additional information for appeals lacking information to reduce overturns Although individual members were addressed, such as follow-up of members with COPD, MCO-level initiatives based on available data were not evident other than the PIPs. A multi-disciplinary local MCO Quality Management meeting is a good forum to facilitate such initiatives. For example, substance use disorder	

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			utilization was prevalent, and there were some infants in 2014 with diagnoses of neonatal abstinence syndrome (NAS). However, self reported substance use on HRAs, including among women of child bearing age, are not further assessed if the member submits the HRA, unless the member is pregnant. Further, implementation of SBIRT by PCPs does not appear to be progressing. Collaboration among the various departments in QM Committee meetings can facilitate the identification of patterns such as these, and all departments should participate in quality improvement programs. **Recommendation for Anthem** Anthem should ensure that the MCO conducts and documents analysis of available data; presentation to and review of QI activities to by the Kentucky health MCO committees; development and implementation of interventions for improvement and re-evaluation to assess for improvement. This analysis of available data should not be delayed awaiting a second year of data to be reported.	

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			Final Review Determination No change in review determination.	
The QAPI program shall be developed in collaboration with input from Members.	Minimal - Addressed in the QM PD, Appendix A, which indicates that a responsibility of the Quality Member Access Committee (QMAC) is to "Provide input into the QM program results and outcomes, and future program goals and interventions." Anthem has established the Kentucky QMAC as of Q3 2014, and the MCO held a meeting in October 2014. Since this was the first meeting, it consisted of an orientation at which members were given committee member materials for review. The membership is comprised of member advocates; as per onsite staff, the MCO has attempted to recruit MCO members for participation	Minimal	This requirement should be addressed in the QM PD, Appendix A, page 11, which indicates that a responsibility of the Quality Member Access Committee (QMAC) is to "Provide input into the annual review of policies and procedures, the QM program results and outcomes, and future program goals and interventions." Anthem established the Kentucky QMAC in Q3 2014. There were meetings in 4 locations (North, South, East and West Kentucky) between August and October 2015, although the committee description states that the QMAC will meet quarterly. These appeared to be introductory meetings and the attendees were provided materials to review and Anthem staff covered informational topics and requested input. The membership continues to be comprised of member advocates, according to the sign-in sheets. Some attendees identified as members, but it was clarified that they	A separate QMAC CAP addressing this requirement was submitted to DMS and accepted on 3/10/16.

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	without success thus far, but efforts to recruit geographically representative members are ongoing. The MCO conducted a member survey in November 2014, the results of which will be available in 2015. **Recommendation for Anthem:** Anthem should continue efforts to recruit MCO members to participate in the QMAC, ensure that QMAC meetings are held as required, ensure that the QMAC fulfills required functions (e.g., review of member education materials), and ensure that relevant components of the QAPI program are developed with consideration of member input. **MCO Response**: The QMAC meetings are currently taking place in different regions of Kentucky. Recruiting efforts		were advocates or government agency staff who were commercial members. Onsite staff indicated that they were continuing to develop strategies to recruit members for committee participation, but were having difficulty in successfully recruiting. They plan to include information in member newsletters and hold meeting in 8 regions in 2016. **Recommendation for Anthem** Anthem should continue efforts to recruit MCO members to participate in the QMAC, ensure that QMAC meetings are held as required, ensure that the QMAC fulfills required functions per the contract and the committee description, and ensure that relevant components of the QAPI program are developed with consideration of member input. **Final Review Determination** No change in review determination.	

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	for members to attend are ongoing and new approaches are underway. For example, the member liaison contacting members that have filed grievances to inquire if they are interested in membership. With previous established relationships between the liaison and the member, the hope is the member will be interested in further involvement in process improvement. **Final Review Determination:** No change in review determination. Anthem should ensure that recruitment of members for the QMAC is conducted as planned and that the committee fulfills its required functions.			
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Substantial - Addressed in Medicaid Business Policy, Health Education Advisory Committee; QM PD, Appendix	Substantial	This requirement is addressed in the 2015 QM PD, Appendix A, Kentucky Committee Structure, page 11, QMAC.	A separate QMAC CAP addressing this requirement was submitted to DMS and accepted on 3/10/16.

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	A, Kentucky Committee Structure, QMAC, on pages 9-10. Note that in the policy, there is no exception for Kentucky regarding the committee name, Quality and Member Access Committee, whereas, this is addressed for other states. The committee was established in Q3 2014 and the first quarterly meeting held in October 2014. The meeting minutes reflect input from the committee and feedback to members. As described above, the committee membership was comprised of member advocates, and no MCO members have yet joined the committee. The committee description indicates that members of various cultural groups will be invited to join. **Recommendation for Anthem:** Anthem should		Anthem established the Kentucky QMAC in Q3 2014, there were meetings in 4 locations (North, South, East and West Kentucky) between August and October 2015, although the committee description states that the QMAC will meet quarterly. The meeting minutes were provided for all meetings and do reflect input from the committee and feedback to members of the committee. As described above, the committee membership was comprised of member advocates, and no MCO members have yet joined the committee. The committee description indicates that members of various cultural groups will be invited to join. **Recommendation for Anthem** Anthem should ensure that recruitment of members for the QMAC is conducted as planned and that the committee fulfills its required functions. **Final Review Determination** No change in review determination.	

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	continue efforts to recruit MCO members to participate in the QMAC, ensure that QMAC meetings are held as required, ensure that the QMAC fulfills required functions (e.g., review of member education materials), ensure that relevant components of the QAPI program are developed with consideration of member input, and ensure that this is documented in the meeting minutes. **MCO Response:** The QMAC meetings are currently taking place in different regions of Kentucky. Recruiting efforts for members to attend are ongoing and new approaches are underway. For example, the member liaison contacting members that have filed grievances to inquire if they are interested in membership. With previous established relationships between the			

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	liaison and the members, the hope is the members will be interested in further involvement in process improvement. **Final Review Determination:** No change in review determination. Anthem should ensure that recruitment of members for the QMAC is conducted as planned and that the committee fulfills its required functions.			
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	Not Applicable - The QM PD, on page 14, indicates that Disease Management Centralized Care Unit (DMCCU) holds NCQA accreditation. Throughout the QM PD there are references to compliance with accreditation standards (e.g., credentialing process). Appendix A, on page 4, states that the local Kentucky QMC is responsible for ensuring	Full	Anthem submitted evidence of preparation for NCQA accreditation, including QI Work Plan entries, a gap analysis, and a matrix of NCQA requirements and documentation to demonstrate compliance. The survey was scheduled for June 2016, but has been delayed by NCQA and will be conducted later in the summer. In response to the prior year recommendation, Anthem included accreditation preparation in the QI Work Plan.	

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	that structure and processes meet accreditation requirements. Appendix B, page 2, QI resources, references that the Corporate Clinical Quality Department will support preparation for the accreditation survey. The 2014 QM Work Plan contains references to NCQA requirements for various domains (e.g., HEDIS, member experience, delegation oversight) but there is not a specific task related to seeking and preparing for NCQA accreditation. MCO prepared for and underwent an NCQA accreditation readiness survey, and the staff provided a copy of the readiness survey results at the onsite review. **Recommendation for Anthem:** Anthem should add a task related to NCQA			

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	accreditation to its QM Work Plan, with the goal of accreditation for its Medicaid product line within 2-4 years. **MCO Response:** The QM Work Plan will be updated in Q2 to reflect work toward NCQA accreditation in 2-4 years from 1/1/2014 when the business began. **Final Review Determination:** Remains not applicable at this time. However, upon the next annual review, IPRO will evaluate the QIPD and QI Work Plan for inclusion of NCQA Accreditation activities.			
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	Not Applicable - This requirement is not applicable, as the MCO has been in operation only one year and has not yet had an accreditation review.	Not Applicable	Accreditation survey preparation is in process.	

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Annually, the Contractor shall submit the QAPI program description document to the Department in accordance with a format and timeline specified by the Department, after consultation with the Contractor.	Full - This requirement is met by confirmation that annual Report #84 QIPD was submitted in Q3 2014 (July 2014).	Full	This requirement is met by confirmation that annual Report #84 QIPD was submitted in Q3 2015 (July 2015).	
The Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.	Full - Addressed in the 2014 QM PD, on pages 3-6, Introduction and Mission, Scope, QI Program Goals and on pages 11-12, Key Program Initiatives. Anthem provided documentation of preliminary HEDIS rates (November and December 2014) for several BH measures; some had eligible populations of < 30 or 0. Anthem will report its first HEDIS submission in June 2015. The MCO is participating in the Statewide Collaborative PIP that focuses on use of psychotropic medications for children and adolescents.	Full	Addressed in the 2015 QM PD, in the Mission, Purpose, Goals, Scope, Objectives, and Key Program Initiatives and in the QI Work Plan, HEDIS tab. In 2015, Anthem submitted its first data for HEDIS BH measures. In addition, the MCO is participating in the 2 Statewide Collaborative BH PIPs - use of psychotropic medications for children and adolescents and management of health risks for adults with SMI.	
The Contractor shall collect data, and monitor and	Not Applicable - This is not	Minimal	Integration of behavioral health (BH) and	Anthem is completing the 2015 Annual evaluation and will

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evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	feasible at this time, as the MCO initiated operations in January 2014. However, integration of behavioral health (BH) and physical health (PH) is addressed in the 2014 QM PD. In addition, BH is incorporated throughout the 2014 QM PD, in the introduction, purpose, goals, scope, initiatives, resources, and committees. During the onsite in interview, staff indicated that the MCO has not yet identified how improvement in PH outcomes from BH integration will be measured. MCO Report #118 Behavioral Health Outcomes includes BH counts and does not address improvements to PH outcomes.		physical health (PH) is addressed in the 2015 QM PD and BH is incorporated throughout the 2015 QM PD. The 2014 QI Evaluation addresses PH/BH integration and BH initiatives. The population assessment revealed that BH conditions are highly prevalent across all age groups. Three of the top 10 inpatient diagnoses are BH conditions: MDD, mood disorder, and depressive disorder. Top inpatient and outpatient diagnoses include: - 0-12 years of age – mood disorder, neonatal drug withdrawal, ADHD, and conduct disorder. - 13-19 years of age – mood disorder, ODD, bipolar disorder, cyclothymic disorder, depressive disorder, MDD single and recurrent, and ADHD. - 20-64 years of age – MDD, depressive disorder, ETOH withdrawal. It appears that in this section of the QI Evaluation, the MCO concludes that the	identify and implement strategies to evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.

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			current programs and resources are sufficient to address these needs. Pancreatitis is also a prevalent inpatient diagnosis. Additionally, the QI Evaluation reports that the largest cohort of members with Chronic Illness Intensity Index diagnoses are substance and alcohol abuse but that current DM programs are adequate to address this. The MCO reported in the QI Evaluation that in 2015, Morpace would conduct a behavioral health appointment availability survey; however, this was not noted in the 2015 QI Work Plan. Onsite staff indicated that the report was delayed and now scheduled to be completed in January 2016. However, Anthem did report efforts to better integrate PH and BH within the UM, DM, and CM programs via MCOs for training, joint rounds, routine BH screening for members in CM, increased staffing, and the addition of staff with BH expertise, as well as accessing available community resources and creating programs dedicated to members with	

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			SMI. These initiatives were not found in the QI Work Plan or committee discussions. Anthem submitted a proposal for the Statewide Collaborative PIP for management of health risks in adult members with SMI and submitted baseline data for the collaborative PIP for antipsychotic use in children and adolescents. Onsite staff did not report current collection of data to monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care. Utilization data reveal some areas that could be explored, such as depression and substance use disorder screening and treatment among members with physical health conditions or pregnancy. **Recommendation for Anthem** Anthem should identify and implement strategies to evaluate for improvements to physical health outcomes resulting from behavioral health integration into	

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			the Member's overall care. **Final Review Determination** No change in review determination.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes to meet the needs of Members. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report as specified by the Department.	Not Applicable - Anthem has not yet completed/approved its first QM Program Evaluation, since the MCO has been operational only since 1/1/2014. The QM Program Evaluation is included as an annual task in the 2014 QM Work Plan.	Full	Includes review of MCO Report #85 QI Plan & Evaluation. In 2015, Anthem prepared its first annual QI Evaluation for the period 2014. The report indicates that the following were accomplished: the MCO entered the Kentucky Medicaid program statewide, except Region 3; managed potential quality of care concerns; monitored patient safety; evaluated cultural and linguistic needs of membership; established all functional areas for member care and services; and founded MCO committees (QI, MAC, and QMAC). Anthem is not yet able to trend many quality metrics due to the short time in operation. The MCO identified the following barriers: limitations in systems logic/support; staffing changes as needs were identified;	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			being a new MCO in the Kentucky Medicaid program; provider and member lack of familiarity with Medicaid managed care. The MCO identified the following priorities for 2015: submit NCQA accreditation application; conduct the first annual member CAHPS and provider satisfaction surveys; conduct outreach to members with the goal of achieving the 50th NCQA percentile for performance measures identified by DMS; develop a provider incentive program; continue to monitor and enhance availability and access to care; reduce unnecessary ED visits; and successfully complete the first EQRO compliance review.	
22.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Full - Anthem has submitted the documentation requested by the External Quality Review Organization (EQRO) related to PIPs, focused studies and the compliance review. The MCO has not yet been required to report performance measures.	Substantial	Anthem has submitted documentation requested by the External Quality Review Organization (EQRO) for PIPs, focused studies and the compliance review. MCO staff was extremely helpful in providing information onsite when requested. The MCO has submitted medical records as requested for the clinical focused study	Additional data validation steps are in place.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Prenatal Smoking. The MCO reported the Kentucky performance measures as required, but had some difficulty producing some of the data necessary for the administrative validation component of the EQR performance measure validation (EPSDT/dental). For the 2016 EQRO review, the MCO was unable to identify and produce provider grievance files for review due to system issues. In addition, the MCO was unable to appropriately identify DCBS members engaged in care management. The sample included former DCBS clients, who could not be differentiated from current members. **Recommendation for Anthem** Anthem should ensure that data systems can be reliably queried to identify member and other data for external and internal quality improvement reviews and initiatives. **Final Review Determination** No change in review determination.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.	Full - Anthem has submitted documentation requested by the EQRO related to PIPs, focused studies and the compliance review. The MCO has not yet been required to report performance measures and the MCO has not yet undergone review for the EQR Technical Report. Anthem staff was available for questions and interviews and files for the file review activities were provided during the onsite component of the compliance review	Full	Anthem has consistently cooperated in submitting documentation requested by the EQRO related to PIPs, focused studies, the compliance review, among other tasks. As described previously, the MCO has undergone the first review for the EQR Technical Report. Anthem staff was available for questions and interviews. Most files for the file review activities were provided during the onsite component of the compliance review, although systems issues prevented the identification of provider grievances and appropriate DCBS care management files as described above. The MCO was extremely cooperative, however, with providing all other information and participating in staff interviews.	
22.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Full - This is the first administrative compliance review for Anthem. The MCO has cooperated with all requests.	Full	The MCO has cooperated with all requests related to the compliance review, despite data limitations as described above.	
The Contractor shall assist the Department and the	Full - Anthem submitted	Full	Anthem submitted eligible populations,	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.	eligible populations, provider and member information and medical records as requested by the EQRO.		provider and member information and medical records as requested by the EQRO.	
22.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - There have been no adverse findings for Anthem to date. However, the QM PD addresses EQR findings and regulatory compliance on page 19, State-specific/Contractually Required Activities and Initiatives, page 20, QI Annual Evaluation, page 3 Program Goals, page 5, Scope and page 11, Key Initiatives, related to individual activities.	Full	Anthem provided a policy and procedure, Corrective Action – Regulatory Audits – Kentucky. The 2015 QM PD addresses EQR findings and regulatory compliance and EQR. Anthem received the findings and first corrective action request related to the 2015 EQR compliance review. A CAP request letter was sent by DMS on 11/30/2015, with the CAP due within 60 days. Onsite staff indicated progress to completion of CAP within the 60 day period.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - Although there have been no adverse findings, Anthem has an assigned a liaison for EQR	Full	This is stated in the policy Corrective Action – Regulatory Audits – Kentucky. .	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	communications.			
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan;	Full - There have been no adverse EQR findings for Anthem; therefore, this would not appear in the QMC or QIC minutes as of this review. However, this requirement is addressed in the QM PD, Appendix A, Kentucky Committee Structure, QMC, Responsibilities.	Minimal	This requirement is stated in the policy Corrective Action – Regulatory Audits – Kentucky; however, there is no evidence that the QM or QIC committee was informed. Onsite staff indicated that final findings were received in November 2015 and would be reported to the QMC and QIC. However, as noted above, there was no discussion in committees of any EQR findings, and the QMC did not meet in 2015. **Recommendation for Anthem** Anthem should inform QM and QIC committees of EQR findings as planned, and engage quality committees in strategies to address findings. **Final Review Determination** No change in review determination.	Anthem will inform QM and QIC committees of EQR findings and engage quality committees in strategies to address findings.
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification;	Minimal - The MCO did not provide a Policy and Procedure for corrective action plans as is required by the contract.	Full	Anthem received the findings and first corrective action request related to the 2015 EQR compliance review. A CAP request letter was sent by DMS on 11/30/2015, with the CAP due within 60 days. Onsite staff indicated progress to	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Anthem provided a Corrective Action Plan dated March 26, 2014 that demonstrated compliance in response to a DMS notice of corrective action for Provider Program Capacity Demonstration dated March 11, 2014. **Recommendation for Anthem:** Anthem should develop, approve, and implement a Policy and Procedure to address the contract requirements related to Corrective Action Plans. **MCO Response:** Develop a Policy and Procedure for corrective action plans according to contract requirements in Q3. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure is developed and that a copy is provided to DMS once it is approved		completion of CAP within the 60 day period.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	internally.			
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full - Addressed in the QM PD, page 3, Purpose, page 8, Objectives of the QI Program, page 19, State-specific/Contractually Required Activities and Initiatives and page 20, QI Annual Evaluation. Demonstrating progressive and measurable improvement is not yet applicable since the MCO has only been in operation since January 2014.	Substantial	Addressed in the 2015 QM PD, Purpose, Objectives, State-specific/Contractually Required Activities and Initiatives, in the 2014 QI Annual Evaluation, and in the 2015 QI Work Plan, with the accreditation and contract requirements. Onsite staff indicated that the MCO has not yet had an opportunity to respond to the EQR Annual Technical Report findings. Anthem received its first EQR preliminary review findings in September 2015. Demonstrating progressive and measurable improvement will be determined by the findings of this review and through the CAP to be submitted by Anthem in response to the DMS request issued November 30, 2015. As noted above, there was no documentation of discussion of preliminary findings and actions to address them in committee meetings. Rather, as per onsite staff, the owners were provided with their results. While some elements with opportunity for improvement were addressed, others are pending.	Anthem will inform QM and QIC committees of EQR findings and engage quality committees in strategies to address findings. Improvement efforts and achievement will be documented and tracked for improvements.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem Anthem should ensure that the results of the External Quality Review (EQR) are incorporated into the QAPI program and improvement demonstrated. **Final Review Determination** No change in review determination.	
E. If Contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.	Not Applicable - Not applicable at this time, no EQRO findings have yet been provided to the MCO.	Not applicable	Anthem has not expressed disagreement with any of the findings from the 2015 EQR review.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that	Full - Anthem submitted quarterly Report #17 QM Work Plan with updates in April 2014 (Q1 2014), July 2014 (Q2 2014), October 2014 (Q3 2014), and January 2015 (Q4 2014).	Full	Includes review of MCO Report #17 QAPI Work Plan Anthem submitted its 2015 QM Work Plan with its quarterly reports in 2014 and 2015 and for the compliance review.	
outlines the scope of activities and	Full - Addressed in the QM Work Plan. There are tabs for each of the activities in the Excel workbook.	Full	This requirement is addressed in the 2015 QM Work Plan. There are tabs for the various activities – accreditation/contract compliance, HEDIS, member experience, quality report submission.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the goals,	Full - Addressed in the QM Work Plan. There is a column for Measurement, Benchmark/Goals. Many activities do not have goals designated as there is no baseline data to establish goals at this time.	Full	This requirement is addressed in the 2015 QM Work Plan. There is a column for Measurement, Benchmark/Goals. Goals are set for many of the metrics for the first time, since 2015 is the first reporting year for Anthem.	
objectives, and	Full - Addressed in the QM Work Plan. There is a column for Activity/Objectives.	Full	This requirement is addressed in the 2015 QM Work Plan. There is a column for Activity/Objectives.	
timelines for the QAPI program.	Full - Addressed in the QM Work Plan. There is a column for timeframe. **Recommendation for Anthem:** Anthem should consider including specific due dates/timeframes in the QM Work Plan, e.g., for a monthly report, the 15th of each month or for a bi-annual report, July 31st and December 31st. **MCO Response:** The 2015 QM Work Plan will be updated in Q2 to reflect DMS	Full	This requirement is addressed in the 2015 QM Work Plan. There is a column for timeframe. In response to the prior year's recommendation, Anthem added the specific due dates/timeframes.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	reports due along with the due dates.			
New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	Full - Since 2014 was the first year Anthem was operating, there are annual goals for 2014 only. The MCO has not yet developed goals for 2015, which will be based on findings from 2014 QI activities. However, in the QM Work Plan, there is a column to indicate if an activity/objective is an identified concern from the prior year.	Full	The 2015 QM Work Plan contains a column to indicate if an activity/objective is an identified concern from the prior year. Anthem has added benchmarks and goals to the 2015 QI Work Plan based on HEDIS and CAHPS benchmarks in Quality Compass. Onsite staff indicated that 2016 goals and objectives will be established based on 2015 results that are not yet available.	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;	Full - Addressed in the QM PD, page 8, Organization Structure and Accountability: Health Plan Board of Directors (BOD) and QM Program Evaluation and in the QM PD Appendix A, Kentucky Committee Structure, page 1, QIC, pages 4-6, QMC, and pages 13-18, Health Plan Board of Directors.	Substantial	This requirement is addressed in the QM Program Description and the Anthem Medicaid KY QM Work Plan. As per the Work Plan, these documents are approved by the MCO and by the corporate QIC Committee. The QM Program Description and QM Work Plan were approved by the Board of Directors and QIC Committee as per minutes. As noted, there were no QMC meetings in 2015, and therefore no documentation of approval by the QMC.	The local QMC is scheduled to meet during Q1 2016 to review Quality Program Description, Work plan and Annual evaluation. Updates to the work plan will be submitted to DMS quarterly (report 17) and reviewed quarterly at the local QMC.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Anthem submitted documentation of review and approval of the QM PD and QM Work Plan by the QMC, with signature of the Chair of the QMC.		**Recommendation for Anthem** Since the Quality Program impacts multiple departments in the MCO, it is essential that the local MCO QM Committee members approve the Work Plan for which they are responsible. Improvement interventions and progress are not documented in the Work Plan. **Final Review Determination** No change in review determination.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - Addressed in the QM PD, page 8, Organization Structure and Accountability: The Health Plan Board of Directors is the governing body of the QM Program and has designated the Corporate QIC to oversee the QM Program and activities. The QIC is directly accountable to the Board. Also addressed in the QM PD, Appendix C, Kentucky Health Plan QIPD QMC Structure and Appendix A, Kentucky Committee Structure, page 1,	Substantial	The QM Program Description page 8 identifies the Corporate QIC as the designated body to oversee the QM Program and activities. The Corporate QIC minutes do not reflect discussion of MCO-specific activities, although they do reflect review and approval of the 2015 QM Program Description, 2015 QM Work Plan and 2014 QM Program Evaluation. Regarding direct oversight of the QAPI Program, there were no meetings of the QMC during 2015. Appendix A of the QM Program Description, Medicaid GBD Committee Structure_Anthem KY, is described as meeting four (6) times per year and responsibilities include activities related to direct oversight of the QM	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	QIC, pages 4-6, QMC, and pages 13-18, Health Plan Board of Directors, page 1, QIC, and pages 4-6, QMC. Note that the description indicates that the BOD meets once annually, and the QMC met only once in 2014.		Program. QMC membership is comprised of MCO management and representatives of multiple MCO departments. **Recommendation for Anthem** The MCO should ensure that the QMC meets regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. There was no documented detailed discussion of the MCO's QM Program Description or QAPI Work Plan and quality of care provided to members in the QIC minutes, although documents were approved by the QIC. **Final Review Determination** No change in review determination.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Minimal - Addressed in the QM PD, page 8, Organization Structure and Accountability: Health Plan Board of Directors and in the QM PD Appendix A, Kentucky Committee Structure, page 1, QIC, pages 4-6, QMC, and pages 13-18, Health Plan Board of Directors.	Substantial	This requirement is addressed in the QM PD page 8 and Appendix A QM Program Description, Medicaid GBD Committee Structure_Anthem KY. The Board of Directors minutes from two meetings in 2015 included review and approval of the QM PD and the QM Work Plan, and the QM Program Evaluation review is on the agenda for September 2015. Grievance and Appeals trends and the EQRO audit were also discussed in the BOD meetings.	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Evidence of review of the QM PD and QM Work Plan by the QMC was provided, but there was no evidence of QMC or BOD periodic review of progress on objectives, QAPI activities and improvements made during 2014. There was only one meeting of the QMC in 2014, and corporate QIC meetings in 2014 did not include evidence of review of Kentucky findings and activities. The MCO did not submit documentation of periodic review by the BOD. **Recommendation for Anthem:** The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. **MCO Response:** The BOD		As noted, the QIC includes review of the QM PD and Work Plan, but the QMC did not meet in 2015 to review QAPI activities, progress and improvements **Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. **Final Review Determination** No change in review determination.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	met in Q1 and has another scheduled meeting in Q2 to review quality activities and documents. Scheduled QMC, QIC and MAC committees are ongoing for 2015 to review and develop additional quality activities and monitoring. **Final Review Determination:** No change in review determination. Anthem should ensure that committee meeting minutes for the BOD, QMC, QIC, and MAC document review and approval of QI Program documents and activities as well as discussion and input, where applicable.			
review on an annual basis of the QAPI program; and	Not Applicable - Addressed in the QM PD, page 5, Scope, in Organization Structure and Accountability: Health Plan Board of Directors and in the QM PD Appendix A, Kentucky Committee Structure, page 1, QIC, pages 4-6, QMC, and pages 13 -18, Health Plan	Substantial	This requirement is addressed in the QM Program Description page 8, which identifies the Board of Directors as responsible for review of the QM Program Evaluation. Appendix A QM Program Description, Medicaid GBD Committee Structure_Anthem KY identifies the QIC as also responsible for review of the QM Program Evaluation. The MCO submitted	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Board of Directors as well as in the QM Work Plan. The structure is in place; however, the first QM Program Evaluation will be conducted in 2015 for CY 2014.		the Anthem Blue Cross and Blue Shield Medicaid Kentucky 2014 Quality Management (QM) Program Evaluation. Approval of the QM Program Evaluation (Trilogy Documents) by the QIC is documented in the August 13, 2015 minutes. Onsite staff indicated that the 2015 QM Program Evaluation would be completed in first quarter 2015. Did prepare the first annual QI Evaluation for CY 2014. As noted, the QMC did not meet in 2015. **Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. **Final Review Determination** No change in review determination.	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Not Applicable - Addressed in the QM PD, page 5, Scope, Organization Structure and Accountability: Health Plan Board of Directors and in the	Minimal	The MCO's first QM Program Evaluation was reviewed in August 2015. Opportunities for improvement were identified in the QM Program Evaluation. The QM Work Plan does not include	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	QM PD Appendix A, Kentucky Committee Structure, page 1, QIC, pages 4-6, QMC, and pages 13 -18, Health Plan Board of Directors as well as in the QM Work Plan. The structure is in place; however, the first QM Program Evaluation will be conducted in 2015 for CY 2014. Modifications to the program based on findings should be reflected in the 2015 QM PD and 2015 QM Work Plan.		interventions related to opportunities identified in the Program Evaluation other than to continue analysis and monitoring and reminders for services overdue. One priority for 2015 was initiation of a provider incentive program for HEDIS measures, and a document describing this for implementation in 2016 was provided onsite. As noted above, there were no QM Committee meetings in 2015, and review of available data and implementation of improvement interventions for finding were otherwise not evident. **Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. This should include modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization, such as trends identified, sentinel events, etc.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Final Review Determination No change in review determination.	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Minimal - Addressed in the QM PD, page 8, Organization Structure and Accountability and in Appendix A, Kentucky Health Plan Committee Structure. The MCO has a Corporate QI Committee (QIC) and a local QM Committee (QMC). However, as described previously, the QMC met only once in 2014 and the Kentucky MCO was on only one QIC agenda and there was no evidence of discussion of the QI Program. **Recommendation for Anthem:** Anthem should ensure that the QMC meets regularly and that meetings are documented in minutes. The MCO should also ensure that for QIC meetings where the Kentucky MCO is an agenda topic, minutes reflect	Non-compliance	Although the QM Program Description Appendix A Medicaid GBD Committee Structure_Anthem KY identifies the QMC as responsible for strategic direction and monitoring and support of implementation of the quality management program, the QMC held no meetings in 2015. QIC Committee minutes include review of Trilogy Documents as the only reference to the Kentucky MCO. **Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. This should include modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization, such as trends identified, sentinel events, etc. **Final Review Determination**	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	the content discussed. **MCO Response:** QIC and QMC meetings are ongoing in 2015 and will have minutes that reflect discussion on quality activities and development. QMC will meet a minimum of 6 times in 2015. **Final Review Determination:** No change in review determination. Anthem should ensure that QIC and QMC meetings are held as required and meeting minutes reflect the committees' fulfilling stated functions.		No change in review determination.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.	Minimal - Addressed in Appendix A, Kentucky Health Plan Committee Structure for QIC and QMC and QMC Calendar document. The QIC meeting minutes reflect membership and attendance by a	Non-compliance	Although the QIC meetings include attendance by a multidisciplinary group of corporate staff members and individual MCO management staff, including health professional members, this committee addressed Kentucky issues at one of 8 meetings held in 2015: approval of trilogy documents. The MCO QMC committee, which does include multidisciplinary MCO	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled. Additional providers in various specialties (including BH) have been recruited for the MAC and will begin serving on that committee in 2016.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	multidisciplinary group of corporate staff members and individual MCO staff physicians and other staff. Health professional members include pharmacists and physicians. Maternal health and behavioral health are represented. The QMC Calendar and meeting agenda reflect membership of multidisciplinary staff from across the Kentucky MCO. While the QMC does not appear to include network providers or health professionals or individuals with expertise with ISHCN, the Medical Advisory Committee (MAC) is described as including 6-10 providers representing primary care, major specialties, delegated entities, and non-voting members representing particular expertise that is not		staff from across the Kentucky MCO as per Appendix A Medicaid GBD Committee Structure_Anthem KY, this committee did not meet in 2015. The QMC does not include network providers. The Medical Advisory Committee (MAC) met three times in 2015, and meetings were attended by 2-4 network providers and the MCO Medical Director, QM Director and HCMS Director. This committee per Program Description should have 6-10 provider members from relevant specialties. Most discussions were centered on utilization and Utilization Management guidelines. In the June 18 meeting, the QM Program Description was reviewed. The QMAC, as described above, met during one quarter in four regions. **Recommendation for Anthem** Anthem should ensure inclusion of participating providers of various medical disciplines relevant to the MCO membership as well as representatives of participating facilities and those with expertise with ISHCN in committee structure. The MCO should ensure that the QMC meets regularly and its QMC	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	otherwise represented. There were minutes from two MAC meetings provided for 2014, and it appeared that provider participation was limited to two providers for one meeting and three for the second meeting. Per onsite staff, general practice, pediatrics and orthopedics are represented on the MAC. The MAC minutes cite plans to expand membership in 2015. Reports from MAC to QMC were not evident, since the only 2014 QMC meeting was held prior to the two 2014 MAC meetings. The QMAC does include a representative from a DCBS regional office and FQHCs. The 2014 QMC meeting preceded the QMAC meeting that was held in 2014, so reporting of QMAC to QMC is not evident. **Recommendation for**		membership represents a multidisciplinary team. **Final Review Determination** No change in review determination.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Anthem: Anthem should ensure inclusion of participating providers of various medical disciplines as well as representatives of participating facilities and those with expertise with ISHCN in its QMC membership and expand MAC membership as planned. **MCO Response:** Anthem has a variety of external medical professionals involved in the MAC with additional recruits in 2015. There are medical professionals from Orthopedics, OB/GYN, Pediatrics and Family Medicine. Behavior Health and ENT recruitment is underway. The QMC committee is currently consisting of an internal multidisciplinary team of leadership. Some though has been given to combining the 2 committees as there is overlap in the information presented and discussed in			

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	each committee. **Final Review Determination:** No change in review determination. Anthem should ensure that additional providers are recruited for and participate in the QMC and MAC, specifically those with expertise in serving ISHCNs.			
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Minimal - Addressed in the QM PD, Appendix A, QIC and QMC descriptions and in the QMC calendar document. As noted previously, Anthem attended the QIC meetings from April – December 2014. Minutes were provided for each meeting; however, Kentucky specific details appear limited to reference to lack of access to the State immunization registry at one meeting. The MCO's QMC met only once in 2014. The committee	Minimal	As above, the QIC met 8 times in 2015 but discussed Kentucky only once and minutes were provided; the MAC met three times and minutes were provided, although as per the QM Program Description Appendix AM the committee is to meet 6 times annually. The MAC focused mainly on UM guidelines. The QMC did not meet at all in 2015. **Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to provide sufficient oversight of the Quality Management Program and activities, including a review of progress on quality management objectives and improvements. This should include	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	description indicates that the committee will meet 6 times a year at a minimum. Since meetings began in 2Q 2014, it would be expected that 3-4 meetings would have been held. **Recommendation for Anthem:** Anthem should ensure that the QMC meets as required and should consider holding QMC meetings monthly (at least 10 times a year) in order to effectively fulfill the scope of responsibilities. **MCO Response:** QIC and QMC meetings are ongoing in 2015 and will have minutes that reflect discussion on quality activities and development. The QMC will meet a minimum of 6 times in 2015. **Final Review Determination:** No change in review determination. Anthem		modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization, such as trends identified, sentinel events, etc. **Final Review Determination** No change in review determination.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	should ensure that the QIC and QMC meet as required and that meeting minutes reflect the committees' fulfilling stated functions.			
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	Full - For Providers, required participation in QAPI activities is addressed in the Provider Manual, page 9, Section 2.1 Provider Responsibilities. Submission of Encounter Records is addressed in the Provider Manual, Section 10 Claim Submission and Encounter Data and provider contract. In the subcontractor contracts, QI and ED requirements are addressed in the Kentucky Contract Addendum/ Attachment, #2 Monitoring, #5 Encounter Data, and #14 Additional Requirements, E. and/or the Managed Services Agreement, 2.6 Reporting Requirements, and/or the	Full	This requirement is addressed in the Provider Manual pages 7-8, and in provider and subcontractor contracts Anthem Health Plans of Kentucky Participating Provider Network Agreement, which include access to records, submission of Encounter Data and quality monitoring. The QM Program Description references inclusion of providers in the QAPI program throughout the document, and subcontractors are addressed on page 15. Anthem also provided evidence of integrating providers and subcontractors into the overall QAPI Program in Performance Improvement Project (PIP) reports, Joint Operations meeting summaries that include collaboration with subcontractors regarding quality indicators and communications documenting collaborating on quality data collection and reporting (EyeQuest), and MAC committee meeting minutes.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	main contract document, Article IV, 4.2 Billing (a) Claim Submission, Article IX, 9.4 QI Program, 9.12/9.14. Providing feedback on the integration, operation, and corrective actions necessary in Provider and Subcontractor QAPI activities is addressed in the QM PD on page 5 and page 7, and Page 19, Section XV, Quality Improvement Annual Evaluation. The MCO incorporates QAPI activities of providers participating in Health Homes and Patient Centered Medical Homes, and meets quarterly with subcontractors to review QAPI activities. Onsite staff indicated that quality improvement activities are not delegated to subcontractors.			
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and	Full - Addressed in the QM PD, page 4, QI Program Goals, page 5, Program Scope, and	Minimal	This requirement is addressed in the QM Program Description, and MCO management activities such as Utilization	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Appeals, Provider Credentialing, and Provider Services in its QAPI program.	Program Methodology, starting on page 9, Key Initiatives on pages 11 – 17, and on page 19, Risk Management and in the QM Work Plan under Member Experience, Patient Safety, Member Connections, Provider Satisfaction, and Credentialing. Integration across departments is also evident in representation on the QMC and the QMC description and meeting agenda.		Management, Member Services, Grievance and Appeals and Provider Services are included in the QM Work Plan and QM Program Evaluation. Some planned interventions for Utilization Management were included in the QM Program Evaluation, and onsite staff provided evidence of follow-up implemented for members with COPD post-discharge to reduce unplanned readmissions. Utilization Management was discussed in the MAC committee minutes and Grievances and Appeals process, Member Services and Provider Directory were reviewed in the QMAC meetings and Utilization Management are reflected in QMAC and MAC committee minutes. Anthem provided weekly QM "Snippets" for staff; these are brief communications regarding quality, grievances and appeals, EPSDT and other topics. Integration was noted as evident in the prior review in representation on the QMC. As noted above, MCO QM Committee meetings can ensure the integration of all MCO department activities into the QM Program. Input	meeting is currently scheduled.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			from various departments can provide valuable insight and additional perspective on opportunities for improvement. Although integration of multiple department activities is evident in the QMC description, there were no QMC meetings in 2015. Anthem provided evidence of meetings between UM, appeals and QM to discuss strategies to address appeals overturns. **Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to implement the integration of multiple department activities across the MCO into the QAPI Program as described in MCO documents. **Final Review Determination** No change in review determination.	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including, but not limited to, monitoring and evaluation of Member's care and services, including the care and services of Members with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Members	Substantial - Resources are addressed in the QM PD, pages 8 & 9 and in Appendix C, Resources and in the QM Work Plan. Onsite staff provided an organizational chart that documented 61 staff	Full	Anthem provided an updated organizational chart with designated staff in identified positions and 97 Kentucky staff members. Onsite staff indicated successful recruitment with 13 recent staff additions. **Recommendation for Anthem** Anthem should ensure integration of all	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.	members located in Kentucky. The Kentucky Quality staff includes the Quality Director, Senior Clinical Quality Audit Analyst and two Member Liaisons; there is also a plan Medical Director and, as noted above, multiple departments participate in the QAPI program. The organizational chart provided by onsite staff demonstrates positions in Quality without designated staff, including a Vendor Member Liaison, RN Auditor, Health Outreach Specialist and Business Info Analyst II. As per onsite staff, recruitment for these positions is underway. **Recommendation for Anthem:** Anthem should evaluate the local Kentucky-based staff resources dedicated to the QAPI Program, and ensure that as data are becoming available		appropriate staff into the QAPI Program and QAPI activities.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and improvement initiatives implemented, there is adequate dedicated staff to carry out required activities. **MCO Response:** In 2015 an additional member liaison has been hired as well as a business information analyst. A Quality manager is currently in the process of being hired and recruitment for 2 outreach specialists and 2 quality nurses is currently occurring. **Final Review Determination:** No change in review determination. Anthem should ensure that the open positions are filled, including: member liaison and a business information analyst (hired), a quality manager, 2 outreach specialists and 2 quality nurses.			
The Contractor shall submit the QAPI work plan to the Department annually in accordance with a format and timeline specified by the Department.	Full - The QM Work Plan was submitted to DMS quarterly as required.	Full	The 2015 QM Work Plan was submitted to the Department as required and includes designated staff, reporting	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	The Work Plan includes designated responsible staff, whether an issue was identified in prior year, reporting requirements, benchmarks and goals, improvement interventions, timeframes, and quarterly updates (date and status). **Recommendation for Anthem:** The MCO could consider including reporting dates for applicable tasks, such as submission of annual reports. **MCO Response:** The 2015 QM Work Plan will be updated Q2 to reflect due dates for specific tasks and reports.		requirements, benchmarks and goals, improvement interventions for some issues, and quarterly update entries.	
19.4 QAPI Monitoring and Evaluation				
The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high	Full - Addressed throughout the QM PD, Introduction and Mission, Purpose, QI Program Goals, Program Scope,	Full	Includes review of MCO Report #23 Evidence Based Guidelines This requirement is addressed throughout the QM Program Description, 2014 QM	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.	Objectives of the QI Program, Program Methodology, Key Program Initiatives, and QI Annual Evaluation and in the QM Work Plan. The execution cannot be fully assessed since Anthem began operation in January 2014 and it was not possible to conduct many of the quality measurement activities. Most measurements will be reported for the first time in 2015.		Program Evaluation and the QM Work Plan. Anthem submitted evidence of monitoring and analysis of gaps in receipt of EPSDT services by age group and region, appeals and CAHPS data. The QM Work Plan includes HEDIS result tracking for selected measures with benchmarks and goals, and Anthem provided a HEDIS monthly benchmark report for tracking of measures including Follow Up after Behavioral Health Hospitalization.	
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives, in policies: Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-Kentucky and Clinical Practice Guidelines – Measuring Practitioner Compliance and in the QM Work Plan. Establishing and renewing Clinical Practice Guidelines	Minimal	Although this requirement is addressed in QM Program Description, and guidelines were reviewed by the QIC and the MAC, Anthem provided a screen shot of the Member Provider Outreach Portal for the EPSDT review, and it can be used to monitor EPSDT services by provider. An undated Policy and Procedure EPSDT Provider Tracking and Audit describes monitoring of PCP's EPSDT rates; evidence that monitoring had begun was not provided. Anthem did not provide other evidence of	Medical record reviews have begun that will measure providers in the network with regards to following guidelines. In addition, providers with low quality ratings associated with HEDIS guidelines will have additional outreach.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and UM Guidelines was evidenced in the MAC meeting minutes. Evaluation of provider compliance could not be assessed in 2014. This will be completed with HEDIS 2015 reporting.		measuring providers against practice guidelines for 2015, and none was cited by onsite staff. The MCO's Medical Record Documentation Review Form includes monitoring for the following guidelines: obesity and obesity prevention, diabetes, EPSDT visits, major depression and ADHD. However, at the onsite review, Anthem indicated that medical record compliance reviews will be conducted in conjunction with the HEDIS data collection in 2016. Onsite staff did provide the Provider Quality Incentive Program Description 2016, which is an incentive program for PCPs based on evidence-based quality measures. **Recommendation for Anthem** Anthem should ensure that monitoring of providers for compliance with guidelines is implemented in 2016. Monitoring of compliance with guidelines in an area that has been identified as an opportunity for improvement should be considered. **Final Review Determination** No change in review determination.	
Areas identified for improvement shall be tracked and	Not Applicable - Anthem has	Not Applicable	Anthem has not yet conducted	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
corrective actions taken as indicated.	not yet conducted measurement of provider adherence to guidelines; this will be completed with HEDIS 2015 reporting.		measurement of provider adherence to guidelines. The MCO indicated that HEDIS would be evaluated in 2016, as well as EPSDT reviews, and that no corrective actions had thus far been implemented.	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.	Not Applicable - Not Applicable as above.	Not Applicable	Anthem has not yet conducted measurement of provider adherence to guidelines. The MCO indicated that HEDIS would be evaluated in 2016, as well as EPSDT reviews, and that no corrective actions had thus far been implemented.	
The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Non-Compliance - As noted, the QMC is comprised of multidisciplinary membership, as is the QIC. However, the QMC met only once in 2014, and there was no evidence of analysis of Kentucky specific data or systems issues in either forum. Although HEDIS and other performance measurement data are not yet available, utilization data, HRA completion data, grievances and care management data could be assessed for trends and patterns to identify	Minimal	As noted, the QMC is comprised of multidisciplinary membership, as is the QIC. However, the QMC met only once in 2015, and there was no evidence of analysis of Kentucky-specific data or systems issues in either forum. The MAC is comprised of 2-4 providers and the MCO Medical Director and QM Director. The MAC mainly focused on Utilization Management guidelines as per meeting minutes. Onsite staff indicated that Quality and analytic staff do work together on issues, and provided evidence of meetings scheduled for collaboration by QM and UM to evaluate appeals overturns.	The QMC is scheduled to meet regularly as described in the QM Program Description (PD) to ensure ongoing evaluation of the quality of care provided to members. The 2016 Q1 meeting is currently scheduled.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	improvement opportunities. **MCO Response:** Anthem has a variety of external medical professionals involved in the MAC with additional recruits in 2015. There are medical professionals from Orthopedics, OB/GYN, Pediatrics and Family Medicine. Behavior Health and ENT recruitment is underway. The QMC committee is currently consisting of an internal multidisciplinary team of leadership. Some though has been given to combining the 2 committees as there is overlap in the information presented and discussed in each committee. **Final Review Determination:** No change in review determination. Anthem should ensure that the QMC and QIC are comprised of appropriate multidisciplinary teams and that meeting		**Recommendation for Anthem** The MCO should ensure regular, ongoing QMC meetings in order to implement the integration of multiple department activities across the MCO into the QAPI Program as described in MCO documents. The MCO should ensure that multidisciplinary teams evaluate and address Kentucky-specific data and systems issues. Anthem should ensure that meeting minutes show evidence of ongoing analysis, monitoring and surveillance of available data to identify opportunities for improvement, performing barrier analysis, and addressing findings and developing interventions. **Final Review Determination** No change in review determination.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	minutes show evidence of ongoing analysis, monitoring and surveillance of available data to identify opportunities for improvement, performing barrier analysis, and addressing findings and developing interventions.			
The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.	Full - Anthem submitted its first PIP proposals in September 2014.	Full	Anthem submitted its 2016 PIP proposals and 2015 baseline PIP reports as required.	
The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.	Full - Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives, in policies: Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-KY and Clinical Practice Guidelines – Measuring Practitioner Compliance and in the QM Work Plan. Establishing and renewing Clinical Practice Guidelines and UM Guidelines was	Full	This requirement is addressed in the QM Program description pages 4-7 and 13, the QM Work Plan, 2014 QM Evaluation and the CPGs Matrix 2015, which includes review dates and dates presented to committees. Practice Guidelines are addressed in the Provider Manual, and links to guidelines on the MCO website are provided in the Manual. There is evidence of discussion of guidelines in the MAC committee minutes.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	evidenced in the MAC meeting minutes. Information about the availability of the guidelines is included in the Provider Manuals, provider newsletters and bulletins and through committees. The guidelines are also posted on the plan web site. Newly contracted providers are informed of the clinical practice guidelines through their welcome materials. Clinical Guidelines are communicated to members in the Member Handbook under Wellness Care for Children and Adults and Special Kinds of Health Care Services.			
Mental Health and Substance Abuse practice guidelines shall be submitted to the Department and DBHDID.	New Requirement	Non-compliance	Although Anthem provided evidence of Mental Health and Substance Abuse practice guidelines identified by the MCO, evidence that the guidelines were submitted to the Department and DBHDID was not provided. Onsite staff was not aware of any practice guidelines	Anthem will submit Mental Health and Substance Abuse practice guidelines to the Department and DBHDID as per guidelines.

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			submitted to the Department and DBHDID. **Recommendation for Anthem** The MCO should submit Mental Health and Substance Abuse practice guidelines to the Department and DBHDID as per guidelines. **Final Review Determination** No change in review determination.	
The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals;	Full - Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives, in policies: Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-KY and Clinical Practice Guidelines – Measuring Practitioner Compliance. This requirement is also demonstrated in the MAC minutes and Report #23 Evidence Based Guidelines for Practitioners.	Full	This requirement is addressed in the QM Program Description and the CPGs Matrix, which cite sources for each guideline that are nationally recognized and evidence-based.	
consider the needs of Members;	Full - Addressed in the QM	Full	This requirement is addressed in the QM	

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	PD, Objectives, Program Methodology, and Key Initiatives, in policy Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-KY and the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. Evidenced in the MAC minutes. The QMAC was established in Q3 2014 and has not yet had the opportunity to review CPGs.		Program Description, and MAC Committee minutes. Anthem's CPG Matrix includes guidelines relevant to the MCO's enrollees. Onsite staff indicated that identified needs of Kentucky members are reported in Corporate committees, and provided evidence of attendance at these meetings by the Medical Director. Onsite staff also indicated that the Medical Director was participating in a workgroup to assess guidelines for Hepatitis C, which is relevant to Kentucky members.	
developed or adopted in consultation with contracting health professionals, and	Full - Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives, in policy Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-KY and the QM PD, Appendix A, Kentucky Health Plan Committee Structure, MAC. Evidenced in the MAC minutes and Report #23.	Full	This requirement is address in the QM Program Description and in Appendix A GBD Committee Structure, which identifies the MAC as responsible for reviewing guidelines. MAC review of guidelines is evident in minutes.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reviewed and updated periodically.	Full - Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives, in policy Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-KY and the QM PD, Appendix A, Kentucky Health Plan Committee Structure, MAC. Evidenced in the QM Work Plan, MAC meeting minutes and Report #23.	Full	This requirement is addressed in the QM Program Description and the QM Work Plan. Dates of review and presentation to committees are documented in the CPG Matrix.	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.	Substantial - Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives, Appendix A, Kentucky Health Plan Committee Structure, MAC and in policy Clinical Practice Guidelines – Review, Adoption, Distribution and Performance Monitoring-KY and Clinical Practice Guidelines – Measuring Practitioner Compliance. Establishing and renewing	Substantial	This requirement is addressed in the QM Program Description and the QM Program Evaluation. The Policy and Procedure Development of Marketing and Member Communications will be updated to address prior recommendation to include Kentucky specific procedures to this Policy and Procedure. **Recommendation for Anthem** Anthem should ensure that Kentucky-specific requirements are added to the Policy and Procedure, Development of	Kentucky specific requirements will be added to the Policy and Procedure, Development of Marketing and Member Communications and submitted for approval in March 2016.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Clinical Practice Guidelines and UM Guidelines were evidenced in the MAC meeting minutes. Review by this committee ensures consistency. With regard to member education materials, consistency with Clinical Practice Guidelines is ensured per Policy and Procedure Development of Marketing and Member Communications which indicates that materials are submitted to subject matter experts (SMEs) for review. The list of states to which the Policy and Procedure applies includes Kentucky. However, elsewhere in the document where the specific states are referenced, Kentucky is not addressed. For example, the procedure used: Aprimo or Collateral Materials Approval Process (CMAP); the review of communication to CMAP or		Marketing and Member Communications. **Final Review Determination** No change in review determination.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	subject matter experts (SMEs) for approval; and the state-specific approval timeframes. **Recommendation for Anthem:** Anthem should address Kentucky-specific procedures in the Policy and Procedure. **MCO Response:** Kentucky specific requirements will be added to the Procedure Development of Marketing and Member Communications policy in Q2. **Final Review Determination:** No change in review determination. Anthem should ensure that Kentucky-specific requirements are added to the Policy and Procedure, Development of Marketing and Member Communications.			
20.1 Kentucky Outcomes Measures and HEDIS Measures				

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall implement steps targeted at health improvement for selected performance measures, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Not Applicable - The MCO will report HEDIS and Kentucky Performance Measures for the first time in 2015. These are listed as tasks on the QM Work Plan.	Substantial	Onsite staff provided evidence of tracking of Follow-Up after Behavioral Health Hospitalization, and the QM Work Plan notes some interventions for HEDIS measures such as member and provider reminders for overdue services (EPSDT) and prenatal member materials. The MCO also participated in a CAHPS workgroup to address CAHPS scores with opportunity for improvement. Onsite staff reported that measures could not yet be trended due to reporting limited to baseline thus far. Anthem's first year of measure reporting was in 2015. **Recommendation for Anthem** Anthem should identify measures with opportunity for improvement when results are available in 2016, and implement strategies for improvement to ensure progress toward goals. **Final Review Determination** No change in review determination.	As noted, 1 year of HEDIS and CAHPS outcomes have been collected. Interventions were in place and currently HEDIS and CAHPS collection is occurring. Once these projects/surveys are completed Anthem will analyze the effectiveness of those interventions and determine next steps.
Additionally, the Department, Contractor, and the EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure	Not Applicable - No measures have been considered for rotation to date.	Not Applicable	No measures have been considered for rotation to date.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
production. The group may consider the annual HEDIS measure rotation schedule as part of this process.				
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.	Not Applicable - DMS has established performance measures for ISHCN prior to Anthem's entering the Kentucky Medicaid program.	Not Applicable	DMS has established performance measures for ISHCN prior to Anthem's entering the Kentucky Medicaid program.	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.	Not Applicable - The MCO will report Kentucky Performance Measures for the first time in 2015; therefore, improvement cannot be assessed at this time. This is listed as a task in the QM Work Plan.	Not Applicable	Anthem submitted some HEDIS measures for which there were adequate denominators in 2015. Trending for improvement will be conducted subsequent to rates available in 2016.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.	Not Applicable - No specific performance targets or goals have been set by DMS to date. The QM Work Plan includes the Kentucky Performance Measures as a task. Since Anthem is reporting for the first time in 2015, there are no updates in the 2014 QM Work Plan.	Not Applicable	No specific performance targets or goals have been set by DMS to date.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Similarly, the MCO is not yet able to prepare and submit an annual report or stratify data to assess for disparities.			
20.3 Reporting HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31st.	Not Applicable - The MCO will report HEDIS for the first time in 2015; therefore the MCO did not submit report #96 for 2014. The MCO noted the following: "Anthem Health Plans of Kentucky, Inc. began its Medicaid business in Kentucky as of 1/1/2014; therefore, no HEDIS project was conducted. This report is N/A for measurement year 2013; reporting year 2014." HEDIS is listed as a task on the QM Work Plan and Anthem calculated preliminary HEDIS rates in November and December 2014.	Full	Includes review of MCO Report #96 Audited HEDIS Reports Anthem submitted Report #96, including the IDSS, audit review table (ART) and final audit report (FAR) for HEDIS 2015.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all	Not Applicable - Anthem is reporting HEDIS for the first	Not Applicable	Anthem reported HEDIS for the first time in 2015. The MCO has only one year of	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.	time in 2015. Anthem will not be able to report on performance trends until reporting year (RY) 2016.		data, and therefore, cannot trend results.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	Not Applicable - Anthem is reporting HEDIS for the first time in 2015. Anthem is advised that the HEDIS rates must be stratified per contract requirements and the MCO should include this in its 2015 QM Work Plan for HEDIS and Kentucky Performance Measures.	Full	Anthem submitted documentation of all reportable Effectiveness of Care and Access/Availability of Care measures stratified by Medicaid eligibility category, race, ethnicity, gender and age. It is important to note, that as a new MCO, Anthem was not able to report all HEDIS measures due to continuous enrollment constraints.	
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.	Not Applicable - DMS has not yet selected a subset of measures for targeted performance evaluation.	Not Applicable	For 2015, DMS did not select a subset of measures for targeted performance evaluation.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based	Not Applicable - Anthem submits encounters as	Not Applicable	Anthem submits encounters as required; however, DMS has not yet calculated and	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	required; however, DMS has not yet calculated and evaluated performance based on encounters. The EQRO, IPRO, has conducted benchmarking studies with comparisons of MCO-reported HEDIS rates and EQR calculated HEDIS rates. Anthem has not been included in the studies since the MCO has not yet reported HEDIS data.		evaluated performance based on encounters. The EQRO, IPRO, has conducted benchmarking studies with comparisons of MCO-reported HEDIS rates and EQR calculated HEDIS rates. Anthem was not able to participate in the past but is now able to do so.	
20.4 Accreditation of Contractor by National Accrediting Body				
If the Contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.	Not Applicable - Anthem has been operating for only 1 year and has not yet obtained accreditation.	Not Applicable	Anthem is currently pursuing NCQA accreditation.	
If a Contractor has not earned accreditation of its	Not Applicable - Anthem has	Full	Anthem has been in operation for two	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the Contractor shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO contract with the Commonwealth.	been in operation for only 1 year and accreditation is not yet required. The MCO has begun preparing for accreditation. **Recommendation for Anthem:** Anthem should include accreditation in its QM PD and QM Work Plan and provide status updates on preparations. **MCO Response:** The QM Work Plan will be updated in Q2 to reflect work toward NCQA accreditation in 2-4 years from 1/1/2014 when the business began.		years and is actively pursuing accreditation. As recommended in the prior review, Anthem included achieving NCQA accreditation in its QI Work Plan and provided status updates on preparations via the gap analysis.	
20.5 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristics and health risks; and the interest of Members in the aspect of care/services to be addressed.	Full - Anthem submitted its first PIP proposals in September 2014. One topic is the Statewide Collaborative BH PIP on Use of Antipsychotics in Children and Adolescents.	Full	Includes review of MCO Reports: #19 PIPs #90 PIP Proposal #92 PIP Measurement Anthem submitted its annual PIP proposals and PIP reports as required. The baseline reports were submitted for	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The MCO initially submitted a PH PIP for Adolescent Well Care Visits; however, due to lack of continuous enrollment, it was not a feasible PIP. On the recommendation of the EQRO, IPRO, and DMS, the MCO submitted an alternate PIP proposal on ED utilization.		the 2015 PIPs: ED utilization and use of antipsychotic medications in children and adolescents. Proposals for the 2016 PIPs were submitted: Dental Care for children and management of health risks in the SMI adult population. DMS approved all project topics.	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and Member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address	Full - This requirement is met by submission of PIP proposals in September 2014 as noted above.	Full	This requirement is met by submission of PIP proposals as directed by DMS.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to Members and Providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.				
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full - Anthem has indicated that the MCO is working with DCBS in managing its foster child members and local health departments are represented on the QMAC. As for other agencies, Anthem has just begun planning its partnerships.	Full	Participation by government agency staff, local health department staff, and other community organizations was seen in the QMAC meeting sign-in sheets and minutes. The MCO meets with DCBS monthly and has been meeting with local health departments and school based clinics.	
The Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures.	Full - Anthem is collaborating with DMS, the other MCOs, and University of Louisville U of L) to conduct the Statewide PIP on Use of Antipsychotic Medications in Children and Adolescents.	Full	Anthem is collaborating with DMS and the other MCOs for the Statewide PIPs on Use of Antipsychotic Medications in Children and Adolescents and Preventive Care for Adults with SMI; participates in the CMS Smoking Cessation Affinity Group and the CMS/CHCS EPSD Dental Quality QI Training group. Anthem also participates in the corporate QIC and the local GBD MCO CAHPS work group.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall monitor and evaluate the quality of care and services by initiating at least one PIP each year and participating in one collaborative PIP each year. The Contractor-specific PIP shall alternate each year of the contract between one relating to physical health and one relating to behavioral health. The first collaborative PIP under this Contract shall have two components addressing both the physical and behavioral health of adults with Severe Mental Illness. The Department shall give the Contractor sixty (60) days' notice for subsequent collaborative PIPs under this Contract. The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED Services. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department shall require Contractor to (i) implement an additional PIP specific to the Contractor, if findings from an EQR review or audit indicate the need for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the	Full - As described, Anthem submitted its first 2 PIP proposals in September 2014. The MCO has been receptive to DMS and EQRO input and recommendations. Anthem submitted MCO Quarterly Report #19, Performance Improvement Projects, documenting status of the PIP proposals for Q3 and Q4 2014.	Full	As described, Anthem submitted its 2 PIP proposals for 2016 and its 2 baseline reports for the 2015 PIPs. The MCO has been receptive to DMS and EQRO input and recommendations.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.				
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:	Full - Anthem reported its PIP proposals on the required reporting template.	Full	Anthem reported its PIP proposals and baseline reports using the required reporting template.	
A. Topic and its importance to enrolled members;	Full - Evidenced in the Project Topic/Rationale for each PIP.	Full	Evidenced in the Project Topic/Rationale for each PIP.	
B. Methodology for topic selection;	Full - Evidenced in the Project Topic/Rationale for each PIP.	Full	Evidenced in the Project Topic/Rationale for each PIP.	
C. Goals;	Full - Evidenced in the Aims/Objectives/Study Question for each PIP.	Full	Evidenced in the Aims/Objectives/Study Question for each PIP. IPRO and DMS have made suggestions regarding target selection in some cases.	
D. Data sources/collection;	Full - Evidenced in the Methodology for each PIP.	Full	Evidenced in the Methodology for each PIP.	
E. Intervention(s) – not required for projects to establish baseline; and	Full - Anthem's PIPs are in the proposal phase; however, the MCO did describe planned interventions for each of the PIPs.	Full	Anthem described the interventions planned and implemented for each of the PIPs. In some cases, DMS and IPRO made recommendations regarding the interventions, as well as process measures.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable -	Anthem's PIPs are in the proposal and baseline phases.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	
B. Did Members participate in the performance improvement project;	Not Applicable - Anthem's PIPs are in the proposal phase.	Full	Member participation is evident in the interventions planned and implemented for each PIP.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	
E. Is there an executive summary;	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	
F. Do illustrations – graphs, figures, tables – convey information clearly?	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be pre-determined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement	Full - Addressed in the PIP proposals submitted in September 2014. Anthem's PIPs are in the proposal phase, so demonstrable and sustainable improvement cannot yet be ascertained.	Full	Addressed in the PIP proposals and baseline reports submitted in 2015. DMS and IPRO made some recommendations regarding targets/goals for improvement. Anthem's PIPs are in the proposal and baseline phases, so demonstrable and sustainable improvement cannot yet be ascertained.	
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full - As noted previously, Anthem submitted its PIP proposals as required.	Full	As noted previously, Anthem submitted its PIP proposals as required.	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.	Not Applicable - Anthem's PIPs are in the proposal phase.	Full	Anthem submitted its baseline PIP reports as required.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than September 1 of the contract year.	Not Applicable - Anthem's PIPs are in the proposal phase.	Not Applicable	Anthem's PIPs are in the proposal and baseline phases.	
D. Conclusion – no more than one calendar year after	Not Applicable - Anthem's	Not Applicable	Anthem's PIPs are in the proposal and	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the first remeasurement and no later than September 1 of the contract year.	PIPs are in the proposal phase.		baseline phases.	
20.6 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.	Full - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. Anthem established the QMAC as of Q3 2014 and held a meeting in October 2014.	Minimal	Includes review of MCO Report #21 MCO Committee Activity This requirement is addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC This requirement is addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. Anthem established a QMAC in 2014 and in 2015, one meeting was held in each of the following areas: North, South, East and West Kentucky. According to Appendix A of the Program Description, Kentucky Health Plan Committee Structure, QMAC meetings are to be held quarterly. According to the sign in sheets and minutes, the attendees were advocates and government agency staff from each community. The MCO reported difficulty recruiting and engaging members and has discussed strategies internally to facilitate recruitment. The MCO held meetings in	A separate QMAC CAP addressing this requirement was submitted to DMS and accepted on 3/10/16.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			four regions to increase potential engagement of members. Onsite staff indicated that meetings would be held in eight regions in 2016. Report #21 was not reviewed, as this report was not submitted by any of the Kentucky Medicaid MCOs. However, the agenda, sign-in sheets, and slide presentation for the QMAC meetings were submitted by Anthem. **Recommendation for Anthem** Anthem should continue recruitment efforts to ensure member representation on QMAC. QMAC meeting should be held quarterly as intended as per QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. **Final Review Determination** No change in review determination.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member	Minimal - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and	Minimal	Addressed in the 2015 QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in 2014 and in 2015, one meeting was held in each of 4 locations around the state.	A separate QMAC CAP addressing this requirement was submitted to DMS and accepted on 3/10/16.

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
participation. Responsibilities of the Committee shall include:	the first quarterly meeting held in October 2014. The committee membership is comprised of representation from various member advocates and community health educators as per the QM PD Appendix A, and as evidenced in committee minutes. The QM PD Appendix A indicates that membership will include MCO members from the major cultural groups served by the MCO. Per committee meeting minutes and onsite staff, there are no MCO members in the committee at this time. In the onsite interview, staff indicated that Anthem is recruiting for member representation. **Recommendation for Anthem:** In 2015, Anthem should continue its efforts to recruit MCO members to		The QM PD Appendix A indicates that membership will include MCO members from the major cultural groups served by the MCO. The committee membership is comprised of representation from various member advocates, community health educators, and government agency staff. There was no evidence that Medicaid members participated, although in the prior review, Anthem indicated that recruitment efforts were in process. Onsite staff indicated that strategies to increase member recruitment were being developed. **Recommendation for Anthem** Anthem should continue its efforts to recruit MCO members to participate in the QMAC. If MCO members are recruited, an updated list of QMAC members should be submitted to DMS. As noted in the contract, Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain Member participation. Anthem should document recruitment efforts to engage	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	participate in the QMAC. Once MCO members are recruited, an updated list of QMAC members should be submitted to DMS. **MCO Response:** The QMAC meetings are currently taking place in different regions of Kentucky. Recruiting efforts for members to attend are ongoing and new approaches are underway. For example, the member liaison contacting members that have filed grievances to inquire if they are interested in membership. With previous established relationships between the liaison and the members, the hope is the members will be interested in further involvement in process improvement. **Final Review Determination:** No change in review determination. Anthem should ensure that members		Members in the QMAC. **Final Review Determination** No change in review determination.	

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State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	are recruited for the QMAC as planned, meetings are held as required, and minutes reflect the committee fulfilling its required functions.			
A. Providing review and comment on quality and access standards;	Full - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and the first quarterly meeting was held in October 2014. The meeting minutes reflect that the committee was asked to provide feedback on any access issues they encounter in the community.	Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that quality and access standards were an agenda item.	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;	Full - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and the first quarterly meeting was held in October 2014. The meeting minutes reflect that the member grievance and	Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that grievance and appeal processes were an agenda item.	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	appeal procedures were explained to the committee.			
C. Providing review and comment on Member Handbooks;	Full - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and the first quarterly meeting held in October 2014. The meeting minutes reflect that a Member Handbook would be mailed to each committee member and all were asked to provide feedback.	Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that the committee was given the Member Handbook to review.	
D. Reviewing Member education materials prepared by the Contractor;	Full - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and the first quarterly meeting held in October 2014. The meeting minutes reflect that the committee members were given member materials for review.	Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that review of member materials was an agenda item.	
E. Recommending community outreach activities; and	Full - Addressed in the QM	Full	Addressed in the QM PD, Appendix A,	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and the first quarterly meeting held in October 2014. The minutes reflect that committee members were asked to share information in the community; however, recommendations for community outreach activities were not yet addressed. **Recommendation for Anthem:** The MCO should ensure that the QMAC is involved in recommending community outreach activities in future meetings. **MCO Response:** Will ensure the QMAC agenda captures involvement in recommending community outreach activities.		Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that discussion of community outreach activities occurred.	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - Addressed in the QM PD, Appendix A, Kentucky	Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Health Plan Committee Structure, QMAC. The committee was established in Q3 2014 and the first quarterly meeting held in October 2014. The meeting minutes reflect discussion of grievance and appeal procedures.		Structure, QMAC. The meeting minutes reflect that in most of the meetings, participants commented and asked questions about Medicaid and Anthem policies.	
The list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC and the QMAC 2014 Calendar. A list of members is found on the meeting agenda for October 2014, and was provided to the Department.	Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. Anthem submitted the sign in sheets for the QMAC meetings held in North, South, East and West Kentucky. Onsite staff cited ongoing efforts to recruit and engage members for participation in QMAC.	
21.5 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current	Not Applicable - This requirement is addressed in the QM PD and the QM Work Plan. Anthem has not yet conducted a Provider Satisfaction Survey or a	Substantial	Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys Anthem submitted Report #94, CAHPS survey results for Adult Medicaid and Child Medicaid CAHPS, including the full	The Provider satisfaction survey for 2015 was conducted and results received. The 2016 survey materials have been submitted to the department for approval and scheduled to be distributed in May 2016 once approved.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	CAHPS survey. These are planned for 2015. The MCO did conduct a member survey regarding satisfaction with the MCO's communication and services in 2014.		report from its vendor, DSS Research, which contains the CAHPS questionnaire. Anthem indicated in Report #95 that the Provider Satisfaction Survey was being completed in Q4 2015. Results were not provided with the pre-onsite documentation. Onsite staff provided evidence that the Provider Satisfaction Survey was initiated in 2015; however, the results report was provided to the MCO in January 2016. **Recommendation for Anthem** The MCO should ensure that Provider satisfaction surveys are conducted annually. **Final Review Determination** No change in review determination.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Not Applicable - Not Applicable as above.	Full	Anthem submitted Report #94, CAHPS survey results for Adult Medicaid and Child Medicaid CAHPS, including the full report from its vendor, DSS Research, which contains the CAHPS questionnaire.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target	Full - Although 2014 was the MCO's first year in operation, Anthem conducted a survey	Full	In the 2014 QI Evaluation, Anthem reported plans to conduct the following special surveys in 2015:	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
subpopulations perspective and experience with access, treatment and services.	of members in November 2014 regarding the MCO's communication and member satisfaction with services as noted in MCO Quarterly Report # 22 Satisfaction Surveys and a sample survey cover letter was provided. Since 2014 was the MCO's first year in operation, the need for other special surveys could not yet be assessed. Note that the EQRO, IPRO, conducted a Children's Behavioral Health Services Satisfaction Survey in 2014 but Anthem was not included due to limited time in operation.		- BH Appointment Availability Survey conducted by Morpace - Case Management Satisfaction Survey. Results for these were not found in the pre-onsite documentation. Onsite staff reported and provided documentation that the survey was conducted and completed December 2015, but the MCO has not yet received the report. Onsite staff also reported results from the 2014 survey of members regarding the MCO's communication that were received in 2015. One important finding was that members prefer written communication from the MCO.	
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Not Applicable - Addressed in the QM PD and the QM Work Plan. Anthem will conduct its first Provider Satisfaction Survey in 2015.	Non-compliance	Anthem did not submit a provider satisfaction survey instrument with the pre-onsite documentation. The January 2016 Provider Satisfaction Survey PowerPoint provided onsite indicates that Anthem developed the survey. Evidence was not provided that the survey was submitted to DMS prior to administration.	The Provider Satisfaction survey materials have been revised and submitted for approval.

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem Anthem should ensure submission of provider satisfaction survey instruments to DMS. **Final Review Determination** No change in review determination.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	Not Applicable - The MCO's first Provider Satisfaction and CAHPS surveys will be conducted in 2015.	Not Applicable	Anthem submitted Report #94, CAHPS survey results for Adult Medicaid and Child Medicaid CAHPS, including the full report from its vendor, DSS Research, which contains the CAHPS questionnaire. Anthem's first Provider Satisfaction Survey was implemented in September 2015, and results were made available January 2016, after the review period. Anthem provided a PowerPoint presentation dated January 2016 with survey results. Notably, provider grievance and appeals process are identified as opportunities for improvement.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem Anthem should ensure the implementation of improvement interventions for identified opportunities for improvement in 2015. Anthem should submit findings and methodology to the DMS as per contract.	
All survey results must be reported to the Department, and upon request, disclosed to Members.	Not Applicable - The MCO's first surveys will be conducted in 2015.	Full	Anthem submitted Report #94 CAHPS report.	
38.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.	Full - Anthem submitted the quarterly QM Work Plan updates to DMS for each quarter in 2014.	Full	Anthem submitted the quarterly QM Work Plan updates to DMS for Q1-Q3 in 2015.	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	58	10	11	4
Total Points	174	20	11	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.47**		

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

QI Program Description (MCO Report #84)
QI Work Plan (MCO Report #17)
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports (MCO Reports #19, 90 and 92)
Quality Improvement Committee description, membership, meeting agendas and minutes
Committee description, membership, meeting agendas and minutes for QMAC
Clinical Practice Guidelines
Provider Manual
Provider Newsletters
Provider Committee minutes

Reports

Annual QI Evaluation Report (MCO Report #85)
HEDIS Final Audit Report and IDSS rates (MCO Report #96)
Healthy Kentuckians Outcomes Measures Report
CAHPS Report (MCO Report #94)
Provider Satisfaction Survey Report (MCO Report #95)
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Evaluation, analysis and follow-up of performance measure results
Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines
Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of services
Evidence Based Guidelines for Practitioners (MCO Report #23)
MCO Committee Activity (MCO Report #21)

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
25.0 Member Grievances and Appeals				
25.1 General Requirements The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B. The Department, by or before January 1, 2016, shall provide a standardized form for all participating MCOs for a Member to begin the Contractor's grievance and appeal process.	Full-2015			
25.2 Member Grievance and Appeal Policies and Procedures				
The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in accordance with the notice, timeliness, rights and procedures in 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. These policies and procedures shall include, but not be limited to:	Full-2015			
A. Provide the Member the opportunity to present evidence and allegations of fact or law, in person as well as in writing;	Full-2015			
B. Allow the Member or the Member's representative prior to and after the appeal to review the Member's case file;	Full-2015			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
C. Consider the Member, the Member's representative, or the legal representative of the Member's estate as parties to the appeal;	Full-2015			
D. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	Full-2015			
E. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a grievance or appeal;	Full-2015			
F. Ensure that a grievance or an appeal is disposed of and notice given as expeditiously as the Member's health condition requires but not to exceed 30 days from its initiation;	Full-2015			
G. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full-2015		Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	
H. If the grievance involves a Medical Necessity determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;	Substantial - This requirement is addressed in Member Complaints and Grievances and Member Appeals – Core Process, section Pre-service Appeals #6, and section Post Service Appeals #6. This requirement is also addressed in Member Complaints and Grievances. <u>Member Grievance File Review Results</u>	Substantial	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results This requirement is addressed in Policy and Procedure Member Complaints and Grievances, page 5 and Member Appeals-KY page 6. <u>Member Grievance File Review Results-</u>	Additional training took place in Q1 2016 for the grievance coordinator and RN overseeing QOC concerns. The grievance coordinator understands signs associated with a QOC concern within a grievance and will have open dialogue with the QOC RN reviewer.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	– Random There were no applicable random grievance files. Member Grievance File Review Results – Quality 5/6 quality grievance files that appeared to involve a clinical issue included documentation of review by a health professional. In one quality file, it was not clear if there was a clinical issue, but it does not appear that a health care professional was involved. Although the member indicated some physical dental complaints, he wished to file a grievance regarding payment only, as per member services file documentation. Member Appeal File Review Results 10/10 appeal files included documented review by a health care professional. **Recommendation for Anthem:** The MCO should ensure that possible quality of care concerns are referred to appropriate personnel by member services. **MCO Response:** Will update the		Random Of 10 reviewed files, 1/10 involved a potential clinical quality concern as well as billing concern. This member's case was recognized as a potential quality of care concern in hospital use of member-specific inhalers, and it was referred to Case Management. The case was closed on the same day, and it is not clear from documentation what the investigation entailed. Member Grievance File Review Results-Quality Of 10 reviewed files, 1/10 included a clinical quality complaint regarding an unknown new medication prescribed by a PCP that may have contributed to an Emergency Department (ED) visit. Although the member was assigned a new PCP, there was no evidence in the file that the clinical aspect of the complaint was addressed. Member Appeal File Review Results-Random 10/10 random member appeal files were appropriately reviewed by a health care professional for medical necessity. Member Appeal File Review Results-EPSDT	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Member Grievance Policy to reflect additional steps for clinical review of potential quality of care concerns within a grievance even when the nature of the primary grievance is not quality of care specific. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure Member Complaints and Grievances and Member Appeals – Core Process is updated to address that potential quality of care issues are referred for clinical review and ensure same. Anthem should submit the revised Policy and Procedure to DMS once approved internally.		5/5 EPSDT member appeal files were appropriately reviewed by a health care professional for medical necessity. **Recommendation for Anthem** Anthem should ensure that potential quality of care issues identified in grievances are referred for clinical review and investigated. **Final Review Determination** No change in review determination.	
I. Process for informing Members, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Full-2015			
J. Provide assistance to Members in filing a grievance if requested or needed;	Full-2015			
K. Include assurance that there will be no discrimination	Full-2015			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
against a Member solely on the basis of the Member filing a grievance or appeal;				
L. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Full-2015			
M. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Substantial - This requirement is addressed in Policy and Procedure, Member Complaints and Grievances, with both policies indicating that "process and all member services and interactions is communicated and administered in a culturally and linguistically competent manner, including those with limited English proficiency and accommodate those individuals with disabilities consistent with the requirements of the American Disabilities Act (ADA) of 1990." Member Complaints and Grievances policy and procedure does not specifically indicate that notices of resolution are provided in a manner to ensure ease of understanding. The Member Complaints and Grievances policy and procedure does not include any Kentucky-specific riders or paragraphs. <u>Member Grievance File Review Results</u>	Full	Includes Member Grievance Random and Member Grievance Quality file review results This requirement is addressed in Policy and Procedure Member Complaints and Grievances, page 8. This Policy and Procedure was provided onsite with Kentucky-specific requirements included, and the updated policy was approved on December 23, 2015. <u>Member Grievance File Review Results-Random</u> 10/10 reviewed random member grievance files included a written notice of resolution in an easy to understand manner. <u>Member Grievance File Review Results-Quality</u> 10/10 reviewed quality member grievance files included a written notice of resolution in an easy to understand manner.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	– Random 9/10 random grievance resolution letters were written in an easy to understand manner. One random grievance file was missing a resolution letter and therefore could not be reviewed for ease of understanding. Member Grievance File Review Results – Quality 10/10 quality grievance resolution letters were written in an easy to understand manner. **Recommendation for Anthem:** The MCO should ensure resolution letters to all members filing a grievance and that the provision of grievance resolution notices in a manner to ensure ease of understanding is included in member grievance policies and procedures. **MCO Response:** Additional audits of grievance procedures will assist in identifying any missed communication with members. Member complaints and Grievances policy will be updated to reflect notices of resolution will be provided in			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	manner to ensure ease of understanding. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure, Member Complaints and Grievances, is updated accordingly and submitted to DMS once approved internally. Anthem should ensure that a resolution letter written in a manner that is easy to understand is issued for each member grievance.			
N. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	Full-2015			
O. Provide for continuation of services, if appropriate, while the appeal is pending;	Full-2015			
P. Provide expedited appeals relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being;	Full-2015			
Q. Not require a Member or a Member's representative to follow an oral request for an expedited appeal with a written request;	New Requirement	Full	This requirement is addressed in Policy and Procedure Member Appeals, page 1. This requirement is also addressed in Member Verbal Acknowledgment Letter template, and Member Handbook, page 48.	
R. Inform the Member of the limited time to present	Full-2015			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
evidence and allegations of fact or law in the case of an expedited appeal;				
S. Provide written notice of the appeal decision;	Full-2015			
T. Provide for the right to request a hearing under KRS Chapter 13B;	Full-2015			
U. Provide for continuation of services, if appropriate, while the hearing is pending.	Minimal - This requirement is addressed in Member Appeals – Core Process, section State Fair Hearing #5 page 23. Although the exceptions section of Member Appeals-Core Process include Kentucky timeframes for filing an appeal (30 days after notification of denial) or to request a state fair hearing (45 days after final appeal notification), the timeframes are not specifically indicated in the State Fair hearing section in relation to continuation of benefits, which reads that member benefits shall continue if "the member or his authorized representative files the appeal timely (timeframes may differ by market)". **Recommendation for Anthem:** The MCO should ensure requirements for continuation of benefits while hearing is pending are consistent with Kentucky contract requirements in policies and procedures.	Full	This requirement is addressed in Policy and Procedure Member Appeals, pages 10-11.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Member Appeals – Core Process policy will be updated Q2 to reflect Kentucky specific language regarding processes followed regarding continued benefits to the member during the appeals and state fair hearing process. **Final Review Determination:** No change in review determination. Anthem should ensure that Policy and Procedure, Member Appeals - Core Process, section State Fair Hearing is updated to reflect the Kentucky-specific requirements and timeframes for continuation of benefits. Once revised and approved internally, Anthem should submit the document to DMS.			
V. Allows a Provider to file a grievance or appeal on the Member's behalf as provided in 907 KAR 17.010; and	Full-2015			
W. Notifies the Member that if a Service Authorization Request is denied and the Member proceeds to receive the service and appeal the denial, if the appeal is in the Contractor's favor, that the Member may be liable for the cost.	New Requirement	Full	This requirement is addressed in Policy and Procedure Member Appeals, page 8 and Member Handbook, page 28.	
If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits must be	Non-Compliance - The Member Handbook addresses the requirements	Full	This requirement is addressed in Policy and Procedure Member Appeals, page 11 and	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
continued until one of the following occurs: A. The Member withdraws the appeal, B. The Member does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision, C. A State Fair Hearing decision adverse to the Member is made, or D. The service authorization expires or authorization limits are met.	with the exception of the requirement of "Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action". The Member Handbook indicates that in order to receive benefits the member must request a fair hearing within ten (10) days of the postmark of the resolution letter. Member Complaints and Grievances and Member Appeals – Core Process, Continuation of Benefits #2 page 19, addresses the requirements but the policy differs from the requirement as follows: "Ten (10) [or other state required time frame] days pass after the health plan mails the notice, providing the resolution of the appeal against the member, unless member, within the ten (10) day time frame, has requested a State Fair hearing with continuation of benefits until the Hearing decision is reached." **MCO Response:** Member handbook will be updated Q2 to include missing language regarding "Fourteen (14)		Member Handbook, page 51.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action". Member Appeals – Core Process policy will be updated Q2 to reflect Kentucky specific language Regarding processes followed regarding Continued benefits to the member during the appeals and state fair hearing process. **Final Review Determination:** No change in review determination. Anthem should ensure that the Member Handbook and the Policy and Procedures, Member Complaints and Grievances and Member Appeals – Core Process, Continuation of Benefits are updated to be consistent with and fully address requirements of the Federal and Kentucky regulations and specifically, that the timeframe is not stated as 10 days from postmark. Once revised and approved internally, Anthem should submit both documents to DMS.			
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department	Substantial - This requirement is addressed for appeal files in Member	Substantial	This requirement is addressed in Policy and Procedure Member Complaints and	Additional training for the grievance coordinator took place in Q1 2016 to

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, an administrative hearing officer, judicial appeal, or closure of a file, whichever occurs later. The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information. Documentation regarding the grievance shall be made available to the Member, if requested.	Appeals – Core Process, "Exceptions" page 26. Maintenance of grievance files is addressed in Member Complaints and Grievances. There is no reference to storage of grievance files for ten years following final decision. **Recommendation for Anthem:** The MCO should ensure that maintenance of grievance files as per Kentucky requirements is addressed in policy and procedure. **MCO Response:** Member Appeals-Core Process policy as well as Member Complaints and Grievances policy will both be updated in Q2 to reflect the 10 year storage requirement of files following the final decision. **Final Review Determination:** No change in review determination. Anthem should ensure that both Policy and Procedures, Member Appeals - Core Process and Member Complaints and Grievances, are updated to reflect the requirement for storage of files for 10 years following the final decision. Anthem should submit the revised Policy and Procedure to DMS once approved internally.		Grievances, page 8 and Policy and Procedure Member Appeals, page 14. As noted above, this information was included in an updated policy approved December 23, 2015. Anthem was unable to identify and provide provider grievance files for review. **Recommendation for Anthem** The MCO should ensure effective systems are in place to identify grievance files for review by the Department or designee. **Final Review Determination** No change in review determination.	include case studies and comprehensive review and documentation to ensure that all aspects of grievances, including HIPAA concerns, quality of care concerns and service delays are investigated, tracked and included in resolution letters. This requirement was added to the grievance coordinator's performance goals. Quarterly spot checks by the Director will be conducted and coordinated with quarterly performance goal checks. Anthem revised the Provider Grievance policy effective 12/1/15 to ensure accurate tracking and reporting of provider grievances. A new tracking system and reporting mechanism were put in place beginning 1/1/16, which will support the identification of provider grievance files for review upon request by the Department or designee.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Grievance File Review				
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution. KAR S 17:010 Section 4 (2) (a)	Full-2015		Includes Member Random and Member Quality Grievance file review results.	
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)	Substantial - This requirement is addressed in Member Complaints and Grievances. <u>Member Grievance File Review Results – Random</u> 9/10 files included a resolution notice. All 9 resolution letters included required information. 10/10 files were resolved within 30 days. <u>Member Grievance File Review Results – Quality</u> 10/10 files included a resolution notice and resolution within 30 days. All 10 resolution letters included required information. **Recommendation for Anthem:** The MCO should ensure that grievance files include notices of resolution of the grievance to the member with all	Minimal	Includes Member Random and Member Quality Grievance file review results <u>Member Grievance File Review Results-Random</u> 10/10 reviewed random member grievance files included a written notice of resolution dated within 30 days of receipt that included investigation findings and disposition. However, 1/10 letters did not include information about one aspect of the complaint, i.e. the potential quality of care concern (QOC) regarding hospital use of inhalers. This case was referred to the Care Management for investigation of a potential QOC and was closed on the same day. Details of the investigation were not included in the file. <u>Member Grievance File Review Results-Quality</u> 10/10 reviewed quality member grievance	Additional training for the grievance coordinator took place in Q1 2016 to include case studies and comprehensive review and documentation to ensure that all aspects of grievances, including HIPAA concerns, quality of care concerns and service delays are investigated, tracked and included in resolution letters. This requirement was added to the grievance coordinator's performance goals. Quarterly spot checks by the Director will be conducted and coordinated with quarterly performance goal checks.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	required information. **MCO Response:** Additional audits of grievance procedures will assist in identifying any missed communication with members. **Final Review Determination:** No change in review determination. Anthem should ensure that a resolution letter is issued for all member grievances.		files included a written notice of resolution dated within 30 days of receipt that included investigation findings and disposition. However, in 2/10 files some of the aspects of the grievance did not appear in documentation of the investigation nor in letters. These included one case of possible HIPAA concern and one issue regarding a new medication and possible reaction causing ED visit. In 1/10 files involving delay in provision of CPAP equipment that was ultimately resolved by the MCO, it was not clear from documentation that there was any tracking of the provider or monitoring of the provider's timely provision of needed equipment. **Recommendation for Anthem** Anthem should ensure that all aspects of grievances, including HIPAA concerns, quality of care concerns and service delays are investigated, tracked and included in resolution letters. **Final Review Determination** No change in review determination.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe. 42 CFR 438.408 (c)	Non-Compliance - This requirement is not addressed in Member Complaints and Grievances generally or for Kentucky specifically, although extensions are addressed for other states in Exceptions. Extensions are addressed for appeals in Member Appeals-Core Process. The MCO should include Kentucky grievance resolution extension requirements in policies and procedures. <u>Member Grievance File Review Results – Random and Quality</u> There were no applicable files in the sample of grievance files reviewed. **MCO Response:** The Member Complaints and Grievances policy will be updated in Q2 to include Kentucky grievance resolution extension requirements. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure, Member Appeals-Core Process, is updated to include the Kentucky-specific grievance resolution extension requirements. Anthem should submit the revised Policy and	Full	Includes Member Random and Member Quality Grievance file review results This requirement is addressed in Policy and Procedure Member Complaints and Grievances, page 9, which includes required information and was approved on December 23, 2015. <u>Member Grievance File Review Results-Random</u> 10/10 reviewed random grievance files were not applicable for extension requirements, as all were resolved within 30 days. <u>Member Grievance File Review Results-Quality</u> 10/10 reviewed random grievance files were not applicable for extension requirements, as all were resolved within 30 days.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Procedure to DMS once approved internally.			
Appeal File Review				
Within five working days of receipt of the appeal, the Contractor shall provide the Member with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)	Full-2015		Includes Member Appeal file review results	
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. KAR 17:010 Section 4 (7)	Full-2015		Includes Member Appeal file review results	
The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe. KAR 17:010 Section 4 (11) and (12)	Full-2015		Includes Member Appeal file review results	
The Contractor shall provide the Member or the Member's	Full-2015		Includes Member Appeal file review results	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)				
The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate. 42 CFR 438.406 (a) (3) (4)	Full-2015		Includes Member Appeal file review results	
For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information: (1) the results of the resolution process; (2) the date it was completed. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Full-2015		Includes Member Appeal file review results	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information:	Minimal - This requirement is addressed in Member Appeals –Core Process, section "Resolution and	Minimal	Includes Member Appeal file review results The IPRO findings in 2015 were: Anthem	The appeal letters are currently in internal review and have been expedited to be submitted to DMS for

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
(1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. 42 CFR 438.408 (e) (2)	Notification" page 20. <u>Member Appeal File Review Results</u> 10/10 files reviewed included written notices with information regarding the right to fair hearing and how to request a hearing and the right to request continuation of benefits while state fair hearing is pending. 0/10 files included written notification that addressed member liability for cost of benefits if the state hearing decision upholds contractor action. **Recommendation for Anthem:** The MCO should ensure that the written notice of appeal resolution includes notification of the potential liability of the member for the cost of continuing benefits if the State Fair Hearing decision upholds the Contractor's action. **MCO Response:** Appeals resolution letters will be updated in Q3 to include notification of the potential liability of the member for the cost of continuing benefits if the state fair hearing decision upholds the MCO's action. **Final Review Determination:** No		should ensure that the appeals resolution letter template and all appeal resolution notices include notice of the member's potential liability for the cost of continued benefits if the State Fair Hearing upholds the MCO's action. For the current review, Anthem responded that updated letters were submitted to NextGen, and that final letters were pending. Onsite staff confirmed that approval of the final appeal resolution letters was still pending. <u>Member Appeal File Review Results-Random</u> 0/8 applicable reviewed random member appeal files included information on how to request continuation of benefits, although the right of the member to do so was included. Only 1/8 applicable reviewed random member appeal files included the required information regarding potential liability. <u>Member Appeal File Review Results-EPSDT</u> 0/2 applicable reviewed EPSDT member appeal files included information on how to request continuation of benefits, although the right of the member to do so was included. 0/2 applicable reviewed	approval. Once approved NextGen will put them in place in the application. The Appeals Coordinator is currently manually adding the language to each appeal as the situation arises. (I.E. have a member uphold or past timely filing, I am editing the language into the letter template for that specific appeal.)

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Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	change in review determination. Anthem should ensure that the appeals resolution letter template and all appeal resolution notices include notice of the member's potential liability for the cost of continued benefits if the State Fair Hearing upholds the MCO's action. Anthem should ensure that the revised notice is submitted to DMS once approved internally.		EPSDT member appeal files included the required information regarding potential liability. **Recommendation for Anthem** Anthem should ensure that updated appeal resolution letters include information regarding procedure for requesting continuation of benefits and potential member liability for continued benefits if the State Fair Hearing upholds the MCO's action. **Final Review Determination** No change in review determination.	
Expedited Appeals File Review				
The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice. KAR 17:010 Section 4 (14) (c)	Full-2015		Includes review results for Member Appeals if expedited	
The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any	Full-2015		Includes review results for Member Appeals if expedited	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay. KAR 17:010 Section 4 (14) (d) and (15)				
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Full-2015		Includes review results for Member Appeals if expedited	
25.3 State Hearings for Members				
A Member may not file a grievance with the state. A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Member, or the Member's representative or legal representative of the Member's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor within forty-five (45) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010. A Member may request a State Fair Hearing for an Action taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B. Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear	Substantial - This requirement is addressed in the Member Handbook "Fair Hearings" page 48 and Member Appeals –Core Process, section "State Fair Hearing" pages 22-23 and Exceptions-KY page 26. The requirement that a member request for State Fair Hearing includes the final appeal decision is noted in the Member Handbook. Member Appeals-Core Process does not include information regarding the automatic ruling in favor of the member should the Contractor fail to comply with state requirements or to appear and present evidence. **Recommendation for Anthem:** The MCO should include consequences for	Full	This requirement is addressed in Policy and Procedure Member Appeals, page 13.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
and present evidence will result in an automatic ruling in favor of the Member. The contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services. The Department shall provide for an expedited State Fair hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the Contractor.	the MCO of failure to comply with State Fair Hearing requirements in policy/procedure. **MCO Response:** The Member Appeals-Core Process policy will be updated in Q2 to include information regarding the automatic ruling in favor of the member should the MCO fail to comply with state requirements or to appear and present evidence. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure, Member Appeals-Core Process, is updated to address that failure of the MCO to comply with the State Fair Hearing requirements for or to appear and present evidence will result in an automatic ruling in favor of the Member. Anthem should submit the revised Policy and Procedure to DMS once approved internally.			
28.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that a Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. The Department on or by January 1, 2016, shall approve a standard Provider Grievance Form to be used by	Minimal - These requirements are addressed in CMXX 002 Provider Claim Appeals – KY and KY GAXX 053 Provider Appeals of Utilization Review Determinations, and the Provider	Minimal	Includes file review summary results for Provider Grievances and Provider Appeals Includes review of MCO Reports: #27 Grievance Activity	Anthem revised the Provider Grievance policy effective 12/1/15 to ensure accurate tracking and reporting of provider grievances. A new tracking system and reporting mechanism were

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
the Contractor to initiate its provider grievance process. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals. Appeals shall be recorded in a written record and logged with the following details: date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the Appeal, disposition of the Appeal, corrective action required and date resolved. Provider grievances or Appeals shall be resolved and the Provider shall receive the resolution within thirty (30) calendar days. If the grievance or Appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall monitor and evaluate Provider Grievances and Appeals. The Contractor shall submit monthly reports to the Department regarding the number, type and outcomes including final denials of Provider Grievances and Appeals. A Provider does not have standing to request a State Fair Hearing.	Manual. The MCO provided 2014 quarterly reports for #27 Grievance Activity, #28 Appeal Activity and #29 Grievances and Appeals Narrative. These reports track provider appeals and grievances. The MCO reported no provider grievances in MCO quarterly report #27 for 2014. <u>Provider Appeal File Review Results</u> 10/10 files met all requirements and were resolved within 30 days. There were no extensions in the sample. The MCO did not submit a list of provider grievances pre-onsite and indicated that there were no applicable files. However, while onsite, the MCO provided the reviewer with a document entitled "Workbasket Summary" that included provider grievance status for Provider Relations-Kentucky, which included 4 resolved grievances in 2014 and 6 open cases as of 12/31/14. Files were not provided for these apparent grievances, so the nature could not be ascertained. **Recommendation for Anthem:** The		#28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) Anthem's response to IPRO's request for eligible case listing for provider grievances was: "we did not include one in our 12/4/15 submission due to current system limitations; however, we will have additional information to share about system enhancements to support the provider grievance process during the on-site survey". The policy referenced in last year's response, Grievance Process-Providers-KY was not provided prior to the onsite visit. While onsite, staff provided Policy and Procedure Grievance Process: Providers-KY. This document was approved on January 11, 2016, beyond the review period. Anthem also provided a copy of the Department-approved Provider Grievance Form that will be used in 2016. Onsite staff further explained that a problem with attempts to track member and provider grievances on one system was identified; provider grievances were not being routed to the MCO but were	put in place beginning 1/1/16, which will support the identification of provider grievance files for review upon request by the Department or designee.

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO should ensure that provider grievances are appropriately classified and tracked and trended, and resolved within timeframes as per contract. **MCO Response**: The Grievance Process-Providers-KY policy has been created and processes within Facets to route provider grievances to the health plan are being tested to ensure proper handling. **Final Review Determination:** No change in review determination. Anthem should ensure that provider grievances are correctly classified and forwarded to the Kentucky MCO for resolution. Anthem should ensure that the list of provider grievances is submitted to IPRO for file review sample selection and that files are presented for review. Anthem should submit the new Policy and Procedure to DMS once approved internally.		misrouted and not being tracked. Provider grievances are now being tracked separately per onsite staff, and the problem should be remedied. Anthem provided a spreadsheet onsite that demonstrated a provider grievance being tracked in 2016. No provider grievance files were provided onsite for review. Onsite staff indicated that the provider grievances reported in Quarterly Reports could not be provided for review. <u>Quarterly Desk Audit Results-Provider Grievances</u> Q1 2015 – One provider grievance reported; no trends noted Q2 2015 – No provider grievances reported Q3 2015 – Report #29 showed no provider grievances in Q3, however Report #27 indicated 2 grievances. Anthem reported that the grievances were initially misrouted and were being processed. Onsite staff indicated that the discrepancy was due to the system issues identified for provider grievances. Q4 2015 – pending <u>Quarterly Desk Audit Results-Provider</u>	

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Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Appeals Q1 2015 - Trend of appeals for denials of Hepatitis C treatment; issue of lack of supportive information. There were 1,688 provider appeals in Q1 2015. 88% of the appeals were completed within the required timeframes. The MCO reported an intake error for appeals with issues regarding routing of correspondence. Some appeals were received after the timeframe for resolution had expired and were administratively overturned. These were not included in the trending analysis due to lack of a second review for medical necessity. New procedures were put in place to decrease the incidence of misrouting of documents. The appeals nurse manager is currently reviewing correspondence intake queues for appeals that were inadvertently misplaced. The pharmacy overturn rate was 31%. The appeals nurse manager will continue to work with the Pharmacy department to identify strategies to increase initial submission of documentation during the 24 hour initial determination window for prior authorizations. In addition, the appeals nurse manager will work with	

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Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Pharmacy and the Medical Director to change coding on denials due to a lack of information (LOI). These appeals are currently coded as criteria not met; changing this to LOI determination will increase the incidence of medically necessary prior authorization requests being overturned and decrease turnaround time for approvals. The MCO is investigating avenues to disseminate information on denied services and guideline requirements, and is considering fax blast or mailing of information pertinent to appeal trends quarterly to providers. Q2 2015 - There were 1663 provider appeals received and 1845 provider appeals resolved in Q2. Regarding timeliness, 93% of all provider appeals were completed within required timeframes. A total of 49% of provider appeals were upheld, 48% were overturned and 3% were partially overturned. Anthem reported that common categories for appeals include Harvoni and Sovaldi for Hepatitis C; epidural steroid injections, and inpatient stays for withdrawal symptoms.	

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Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			The MCO noted a general lack of provider knowledge regarding documentation requirements for prior authorization. Anthem reported the following actions: implementing a new process to improve pharmacy appeal turn-around time, educating providers about the initial pharmacy review process, and educating identified providers about the prior authorization guidelines and process. Q3 2015 - There were 103 provider appeals for medical necessity resolved in Q3 compared to 130 in Q2. 100% of the standard appeals were completed within the required timeframes. 100% of the 3 expedited appeals were completed within timeframe. *Note that Report #28 indicates there were 5,189 medical necessity provider appeals received and 5,336 resolved in Q3 compared to the 103 reported in Report #29. Q4 2015 – Pending The MCO provided a document onsite that included a summary of appeals for Q4 dated January 2016 and indicated that	

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Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			some initiatives were being planned to mitigate some of the issues identified, such as improving processes for initial reviews to address overturn rates and initiating internal meetings with appeals and pharmacy manager and Medical Director to address the process surrounding potential overturns. Anthem provided evidence of a process improvement to track denials for lack of information submitted (LOI) versus criteria not met to identify opportunity for improvement. Dissemination of guidelines and prior authorization processes was also cited for individual providers. The MCO also indicated that national meetings were being held to discuss hepatitis guidelines. <u>Provider Grievance File Review Results</u> No provider appeal files were provided for review. <u>Provider Appeal File Review Results</u> Provider appeals file review was deemed compliant in 2015 and not required for the 2016 review. **<u>Recommendation for Anthem</u>** Anthem should ensure that there is an effective and reliable process in place to identify, resolve and track provider	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			grievances and that reporting is consistent and accurate. The MCO should ensure implementation of the Provider Grievance-KY dated January 2016 is implemented by appropriate staff. Anthem should ensure that provider grievances and appeals are monitored for trends and that strategies to address identified opportunities for improvement include strategies at the MCO level as planned. **Final Review Determination** No change in review determination.	
28.11 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Full-2015			
38.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and	Substantial - **T**he MCO provided 2014 quarterly reports for #27 Grievance Activity, #28 Appeal Activity and #29 Grievances and Appeals Narrative. Reports #27, #28 and #29 are reviewed with quarterly desk audits conducted by IPRO. Recommendations based on the review are below.	Full	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) The 2015 quarterly reports include total # of grievances received, total # resolved and number/percent of grievances resolved within 30 days. In addition, MCO actions	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.	**Recommendation for Anthem:** Actions taken by the MCO in response to analysis of grievances should be more specific such as how member and provider education will be implemented. Issues identified in one quarter should be updated in subsequent quarters until resolved. The narrative report should include total # of grievances received, total # resolved and number/percent of grievances resolved within 30 days. **MCO Response:** Recommendations for enhanced reporting on Report 29 will be incorporated Q2 and ongoing thereafter. **Final Review Determination:** No change in review determination. Anthem should ensure that, in accordance with the quarterly desk review recommendations, the report should include more specific actions taken by the MCO in response to analysis of grievances; issues identified are updated in subsequent quarters until resolved; the narrative report should include total # of grievances received, total # resolved and number/percent of grievances resolved		are more detailed. <u>Quarterly Desk Audit Results-Member Grievances</u> Q1 2015 – Anthem noted grievances related to provider billing practices as a trend. Anthem noted a trend of non-par providers billing the member; opportunity to educate providers-use of Member Services and Provider Services departments for eligibility verification and claims processing information, referrals to out of network providers and protocol for claim submission by out-of-network providers. Provider Relations is working closely with the Member Liaison to resolve issues with non-par provider billing. The Manager of Provider Network Management/Relations will work closely with the Utilization Management department to identify non-par providers that request authorization in an effort to increase capturing new provider contracts. The total number of member grievances received in Q1 was 104. 75 grievances were resolved. Of the 75 grievances resolved, 81.3% were resolved within the required timeframe. Per the MCO, this	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	within 30 days.		issue has been resolved with a replacement associate that was assigned to grievance activity beginning 2/1/15. In addition, bi-annual corporate audits will be conducted along with periodic spot checks by the Quality Director. Q2 2015 – Anthem reported a total of 104 member grievances received and resolved in the Q2. Of the 104 grievances, 99% were resolved within the required timeframe, compared to 81.3% in Q1. The majority of member grievances (61, 59%) were related to providers billing the member. Of those, 25 were associated with out-of-network providers not having valid insurance information on file. There were 10 quality of care grievances, although no specific trend was identified. The MCO reported the following actions: providing member education regarding the responsibility to provide their Anthem identification card, educating providers regarding eligibility verification and claims processing, and educating network providers not to refer members to out- of-network physicians and claim submission protocols. Additionally, Anthem uses the out-of-network authorization requests to identify provider contracting opportunities.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Q3 2015 – Anthem reported a total of 75 grievances resolved in Q3, with no grievances pending in Q3. This is a decrease from the 104 grievances reported as received and resolved in Q2. Of the 75 grievances resolved ~ 99% were resolved within the required timeframe. Anthem has set a goal of 90% for resolution within 30 days. The majority (45) of grievances received were related to provider billing practices, including 24 associated with out of network providers. Of the remaining grievances, 10 were related to Access to Care, 5 were related to Quality of Care, and 15 were related to Attitude and Service. The MCO continues to educate providers regarding the eligibility verification tools and claims processing available on the web and has started educating members on using in-network providers and presenting their ID card at the time of service. *Note that Q3 Report #27 indicated there were 50 grievances received in Q3, with 44 resolved, all timely. Of the 50 grievances, 34 were for Member Billing, 8 related to quality, 4 for access issues, 3 for provider	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			attitude/service and 1 related to benefits/eligibility. Q4 2015 – pending <u>Quarterly Desk Audit Results-Member Appeals</u> Q1 2015 – There were 27 member appeals received and resolved in the quarter. 100% of the appeals were completed within the required timeframes. Q2 2015 - There were 28 member appeals for medical necessity received and resolved in the quarter, consistent with Q1. Regarding timeliness, 100% of expedited member appeals and 94% of the standard member appeals were completed within the required timeframes. A total of 71% of appeals were upheld and 29% were overturned. Q3 2015 - Anthem reported there were 27 medical necessity Member Appeals resolved in Q3 compared to 28 in Q2, with 94% of standard member appeals resolved timely. Anthem noted continued requests for Hepatitis C treatments for members who do meet criteria due to physicians' not using the criteria available.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			There is a lack of physician knowledge regarding the documentation required for submission for review of prior authorizations (both pharmacy and UM authorizations). The MCO has initiated a process where pharmacy reviews are marked for lack of clinical information denials. The Appeals Nurse Coordinator has begun to identify providers in need of education on the prior authorization process and the guidelines for prior authorizations. The Appeals Coordinator will work with Provider Relations to outreach and educate providers. The MCO reported that implementation of the system for coding pharmacy denials for lack of information will need monitoring and follow up and should improve turnaround time. A tracking process has been initiated to monitor the turnaround times on pharmacy appeals. Tracking showed that 40 of 50 appeals had a turnaround time < 16 hours, with 28 of those < 5 hours. In Q3, the number of pharmacy appeals increased from 38 to 43. The overturn rate declined to 28% from 32% in Q2. Of 12 appeals overturned, 9 were due to additional information received.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Q4 2015 - Pending	
The Department or its contracted agent may conduct reviews or onsite visits to follow up on patterns of repeated Grievances or Appeals. Any patterns of suspected Fraud or Abuse identified through the data shall be immediately referred to the Contractor's Program Integrity Unit.	Non-Compliance - No documentation related to this requirement was located. **MCO Response:** Grievances and Appeals policies will be updated to reflect the process of actions to be taken when repeated patterns are established. This process will include, but is not limited to, onsite visits. All patterns of suspected fraud or abuse will be referred to Anthem's Medicaid Special Investigations Unit. **Final Review Determination:** No change in review determination. Anthem should ensure that Policy and Procedures for grievances and appeals are updated to address that the Department or agent(s) may conduct reviews or onsite visits to follow up on patterns of repeated grievances and appeals and that any patterns of fraud and abuse identified are referred to the MCO's Program Integrity Unit. Anthem should submit the revised Policies and Procedures to DMS once approved internally.	Full	This requirement is addressed in Policy and Procedure Member Appeals, page 14 and Policy and Procedure Member Complaints and Grievances, page 9. The Member Complaints and Grievances document was provided onsite and has an approval date of December 23, 2015.	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Grievance System
Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	9	2	3	0
Total Points	27	4	3	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Grievance System
Suggested Evidence

Documents
Policies/procedures for:
- Grievances including handling of quality-related cases
- Appeals
- State hearings
- Maintenance of grievance records

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

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

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

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
35.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.	Minimal - Anthem has not yet established a written Health Risk Assessment policy, but rather submitted Draft HRA Policy GBD CM Policy-00X, which has not yet been finalized. Anthem submitted evidence for this requirement in the form of process documents including the Anthem Blue Cross and Blue Shield Medicaid-Kentucky Medicaid Health Risk Assessment Call Script, KY HRA Paper Screening Tool-Adult Update 1/2/14 and the HRA New Member Flyer. The screening tool and call script ask general questions regarding members' perception of their health needs, and does not specifically include need for preventive services, utilization such as recent hospitalization or specific chronic conditions. The Draft HRA Policy GBD CM Policy-00X identifies HCMS-Case Management as the primary department, and outlines outreach efforts for HRA completion that the MCO indicated were currently in process. The draft policy includes a description of HRA screening to assess needs and the need for case or disease management. However, the MCO's submitted 2014 Anthem Medicaid Case Management Program Description does not include the HRA specifically as a means to identify members appropriate for case management. Onsite staff provided an untitled document that represents the logic for triggers to care management based on HRA responses. These triggers	Substantial	This requirement is addressed in the Anthem Policy and Procedure Health Risk Assessment (HRA)-KY, effective 7/14/15, which outlines the content and procedure for obtaining an HRA and triggering members for care management; the 2015 Case Management Program Description (Case Management Program Philosophy page 6 and Identification page 7); Policy and Procedure Care Management Complex Care Management Overview-KY; and Policy and Procedure Identification and Assessment of Individuals with Special Health Care Needs-KY. The MCO submitted KY HRA Screening Tools for adults and children that address demographics and physical and behavioral health care needs, and disability and chronic conditions are addressed in Care Management Complex Care Management Overview-KY. The Anthem-submitted HRA Screening Tools include a query regarding whether the member has a primary care provider (PCP) with whom they work well, but there is no	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	are not apparent on the call script, and include triage to care management if a member does not have a PCP. The 2014 Anthem Case Management Program Description includes case management assessment of health care needs, continuous case finding through predictive modeling to identify members likely to need case management, and population analyses by the Chief Medical Officer to identify priorities-this is performed annually and includes analysis of eligibility category, race/ethnicity, language, age, disability status and serious mental illness. **Recommendation for Anthem:** Anthem should finalize and implement a policy and procedure for timely health risk assessment to ensure identification of preventive and chronic health care needs of its members. The MCO should ensure that issues identified by HRAs, such as need for a PCP, are appropriately addressed, and that members triggered for care management are appropriately referred. **MCO Response:** The draft policy is completed and the internal approval process has been initiated. The HRA policy and procedure have been implemented. The HRA's, once entered into the Case Management system, trigger that member to a CM system queue if they indicate that they need assistance. A CM Specialist will make outreach attempts to initiate contact, and assist the member as needed, discuss CM		query regarding whether the member needs assistance to identify a PCP. As per Policy and Procedure Health Risk Assessment-KY, if an HRA is conducted by a Case Management (CM) Nurse or Specialist, assistance with identifying a PCP is provided, but it is not clear if the CM database into which mailed HRAs are entered is reviewed for need for PCPs. There were 3/7 completed HRAs in which members indicated they did not have a PCP with whom they worked well. There was no evidence that this was addressed or assistance offered, including one case of a 1 year old child. There were 2/7 completed HRAs that indicated substance use (tobacco in one, and alcohol/drugs in the other), but there was no evidence that these issues were addressed by the MCO. Anthem provided a screen shot of the Atlas NCC process for transfer to Care Management for completion of HRA. This screen shot indicates members needing assistance with completing their HRA should be transferred to Case Management. **Recommendation for Anthem** The MCO should ensure that	**Anthem Response** A revised HRA is in development now. It has been

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	options with the member, and task a Case Manager to complete an in-depth assessment if appropriate. **Final Review Determination:** No change in review determination. Anthem should ensure that the draft HRA Policy GBD CM Policy-00X is finalized, approved and implemented. Anthem should ensure that the Policy and Procedure and related documents address the Kentucky-specific requirements. Anthem should submit the final Policy and Procedure to DMS.		members in need of a PCP or assistance with other issues, such as substance use, as per HRA responses are identified and assisted. The procedure for identifying members with these needs, including needs indicated on mailed-in HRAs, should be included in policies and procedures. **Final Review Determination** No change in review determination.	approved by DMS, and will be in production by 7/1/16. This revised Assessment has added the following: **17. May we help you make an appointment with your primary care provider (PCP)?** **Name and contact number of PCP:** If the answer is Yes, this will trigger a referral to CM to assist. The new HRA will have more focused referrals to either Physical Health or Behavioral Health Case Management queues, based upon a point system related to how the member answers questions. For example, question 17 asks "Do you or have you been using drugs or alcohol?". If the member answers "Yes", that answer is scored as 1 point. The new logic triggers a referral to the Behavioral Health CM queue for 1 point on that question. **The HRA Policy and Procedure states:** "When the completed HRA is received by Anthem, either electronically, as in the case of the IVR-completed HRA's, or on paper for those returned by mail, the information is uploaded or entered into the age-appropriate Kentucky Adult or Pediatric Initial HRA form contained in the Case Management system. Based upon pre-determined system logic, the member information given in the HRA may trigger that individual to the system's CM queue for outreach and a more detailed assessment.

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief a Member is pregnant, the Member shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.	Minimal - It is notable that the Draft HRA Policy GBD CM Policy-00X Health Risk Appraisal does not include reference to the required 30 day timeframe for HRAs for pregnant women. <u>HRA File Review Results</u> Anthem initially provided only 10 HRA files for review. While onsite, an additional 9 cases from the sample of HRAs were provided, for a total of 19/25 files provided. 19/19 files included evidence of a timely initial outreach attempt. 8/9 files receiving initial outreach included timely follow-up attempts when the initial attempt was unsuccessful. Follow-up in 10 files was not applicable (member completed HRA at first attempt). One file had no follow-up phone calls documented. Of the 2 completed HRAs of pregnant women, neither was completed within 30 days. There was no indication in the file whether or not the pregnant woman was engaged in prenatal care. The only item referable to this on the MCO's HRA is a question regarding specialty care that is not specific to obstetrics. There was no indication in the file regarding whether the member needed and/or was referred for prenatal care, although the document that the MCO provided regarding the logic for the HRA call script indicates that pregnant women will be triaged to maternal condition management. **Recommendation for Anthem:** Anthem should	Substantial	Includes HRA file review results This requirement is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY, which includes procedures for screening of new members within 90 days of enrollment and within 30 days for pregnant women. Behavioral health conditions and substance use disorders are included in the KY HRA Paper Screening Tools and Policy and Procedure Health Risk Assessment (HRA)-KY, and this document also indicates that pregnant women are referred for completion of OB Screener and to High Risk OB as indicated by needs identified by the OB Screener. <u>HRA File Review Results</u> A total of 7 HRAs were completed among 25 files reviewed. Two of the 7 HRAs were completed after 90 days; neither of these members was pregnant. It was not possible to identify outreach timeframes for these two files, as outreach timeframes were not included in files with completed HRAs. 17/18 HRA files of members for whom HRAs were not successfully completed contained documented timely	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	ensure timely completion of HRAs for new members, particularly for pregnant women, for whom timely prenatal services are essential for optimal outcomes. The MCO should ensure that its HRA policy includes appropriate timeframes for timely completion of HRAs for both non-pregnant and pregnant members. Pregnant women should be assessed for engagement in prenatal care and referred for appropriate prenatal care. **MCO Response:** Excerpt from Anthem HCMS- HRA Final Draft Policy PROCEDURE: "At least three attempts are made to obtain the completed Kentucky Adult or Pediatric HRA within the required 90 days of enrollment, or 30 days of enrollment for a pregnant member. Upon enrollment to Anthem Medicaid, a state enrollment file is sent by Corporate Enrollment to the Anthem Document Control Center (DCC), which is responsible for mailing both New Member Packets and Kentucky Adult or Pediatric HRA's to the new member address on file, within five (5) days of receipt. The "New Member Packet" contains among other materials, a flyer which instructs the member how to go to the Anthem Medicaid website and complete a HRA for each newly enrolled member in the family.		outreach to members. Documentation of refusals was not included in files, although since some members were reached, but HRAs not completed, there may have been some refusals. On site staff indicated that refusals are tracked, though not provided in files. **Recommendation for Anthem** The MCO should ensure timely outreach (prior to 90 days) to facilitate timely HRA completion. To identify barriers to timely completion of HRAs, it would be helpful to document outreach timeframes for completed HRAs to evaluate whether earlier outreach results in more timely completion. Similarly, tracking of refusals would allow for better evaluation of completion rates to inform improvement initiatives. **Final Review Determination** No change in review determination.	**Anthem Response** **The HRA Policy and Procedure states:** "Upon enrollment with Anthem, a state enrollment file is sent by Corporate Enrollment to the Anthem Document Control Center (DCC), which is responsible for mailing both New Member Packets and Kentucky Adult or Pediatric HRA's to the new member address on file, within five (5) days of receipt. The New Member Packet contains among other materials, a flyer which instructs the member how to go to the Anthem website and complete a HRA for each newly enrolled member in the family. In a separate mailing, each new member is mailed a HRA form for completion, with a postage paid return address envelope included. At any time the CM Nurse or Specialist makes contact with a member, whether by phone or in person and an HRA is not showing completed in

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	In a separate mailing, each new member is mailed a HRA form for completion, with a postage paid return address envelope included. All completed HRA's mailed into the Plan are entered by CM Specialist into the Care Management system using the Kentucky Adult or Kentucky Pediatric HRA assessment form. At any time the CM Nurse or Specialist makes contact with a member, and an HRA is not showing completed in the Case Management System, the CM/CM Specialist will complete the Kentucky Adult HRA with the member. Thirty days following enrollment, each newly enrolled member is who does not have a completed HRA in the Care Management system will begin receiving IVR calls from the IVR vendor for this member outreach process. Eliza will ask the member to complete the HRA telephonically. The following is the sequence of the Eliza calls: Outbound Standard Rules: 2-connects Reach correct person [confirms identity, regardless of whether he continues into the full call]: Goal accomplished Reach non-target: Try again at least 2			the Case Management System, the CM Nurse/CM Specialist will complete the HRA with the member. Thirty (30) days following enrollment, each newly enrolled member who does not have a completed HRA in the CM system will begin receiving Interactive Voice Response (IVR) calls from the IVR vendor (Eliza) for this member outreach process. Eliza will ask the member to complete the HRA telephonically."(multiple calls to reach member occur)

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	person in household [whether they accept or decline message] — days later [only if no inbound call in meantime] Reach answering machine — Try at least 2 days later [only if no inbound call] Busy/No Answer — Maximum of 2 attempts per day, at least 1 hour apart, for up to 3 days Wrong Number or Hang Up — No more outreach attempts Upon member completion of a HRA via IVR, the data is uploaded into the Care Management system, populating the KY HRA form. Finally, if a Case Manager or CM Specialist makes an outreach call to a member, and notes that no Kentucky HRA was completed, the HRA questions will be completed during the call with the members' agreement." Excerpt from Anthem HCMS- HRA Final Draft Policy the HRA is only the first screener indicating pregnancy. If a member is identified on the HRA (or via claim review, personal notification) as pregnant, then Warm Health begins outreach right away with a much more detailed prenatal High Risk OB screener. Depending upon the members answers regarding prenatal history, current conditions or issues with this			

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	pregnancy the member is automatically sent to either an "Urgent" or "High" OB queue; from that queue the OB Case Manager makes contact attempts within 24 hours (Urgent) or 48 hours (High). **Final Review Determination:** No change in review determination. The Policy and Procedure was in draft format. Only 19 files were provided for review. One file for a non-pregnant member did not contain timely follow-up to the initial outreach attempt. The 2 files for pregnant members did not contain an HRA completed within the required 30 days and there was no documentation of referral for prenatal care or prenatal care management. Anthem should ensure that the Policy and Procedure is updated to address the HRA timeframes for pregnant and non-pregnant members and that referral of pregnant members to prenatal care and prenatal care management is documented. Anthem should submit the final Policy and Procedure to DMS once approved internally. Anthem should ensure that all HRA outreach is timely and is documented for each member. Anthem should ensure that referrals to care management for pregnant women as a result of the HRA are documented.			
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have	Minimal - The MCO's outreach procedures for HRA completion are outlined only in the Draft HRA Policy GBD CM Policy-00X Health Risk Appraisal, which has	Substantial	Includes HRA file review results This requirement is addressed in Policy and Procedure Health Risk	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members complete the initial health screening questionnaire which includes the survey instrument for both substance use and mental health disorders.	not yet been finalized. These procedures include two mailings within one week of enrollment, with option to complete online risk assessment, followed by phone calls for non-compliant members. There is no provision for in person assessments. Follow up calls begin if HRA is not completed within 30 days of enrollment; there are no specific outreach procedures for pregnant members in the draft HRA policy. The KY HRA Paper Tool and HRA Call Script include screening for substance use and behavioral health conditions. HRA File Review Results 19/19 files included evidence of a timely initial outreach attempt. File review revealed that 8 HRA files included follow up phone calls after two initial mailings and an initial unsuccessful phone call. One HRA file had no follow-up phone calls documented. Follow-up attempts were not applicable for 10 files (HRA completed). 10/10 completed HRAs included substance use and behavioral health condition screening. **Recommendation for Anthem:** The MCO should finalize an HRA policy that includes outreach procedures to ensure HRA completion, and ensure that reasonable contact efforts by mail, telephone or in person are undertaken for all new members. **Recommendation for DMS:** DMS may want to		Assessment (HRA)-KY, which outlines the procedure for contacting members to complete the HRA, including in-person assessment. The MCO submitted KY HRA Paper Screening Tools for adults and children, and they include screening for substance use and behavioral health conditions. HRA File Review Results 18/25 files did not have completed HRAs. All of these files included 2 or more outreach attempts as per the MCO's policy. In one case, initial telephonic outreach was conducted after more than 90 days had passed. All applicable completed HRAs include queries for substance use and mental health disorders. It is notable that use of alcohol and/or substance in a female member of childbearing age did not trigger outreach for further assessment, and there was no evidence of further assessment of a member who reported smoking 1 pack of cigarettes per day. Timeframes for outreach attempts for completed HRAs were not provided.	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	consider developing, in consultation with the MCOs, either: a standardized HRA tool for use across MCOs, or a list of minimally required contents for MCO-specific HRA tools. DMS may also consider specifying in the MCO contract, the minimum number of outreach attempts and the types of methods to be used, such as at least 3 outreach attempts using at least 2 different methods. **MCO Response:** Adult or Pediatric HRA within the required 90 days of enrollment, or 30 days of enrollment for a pregnant member. Upon enrollment to Anthem Medicaid, a state enrollment file is sent by Corporate Enrollment to the Anthem Document Control Center (DCC), which is responsible for mailing both New Member Packets and Kentucky Adult or Pediatric HRA's to the new member address on file, within five (5) days of receipt. The "New Member Packet" contains among other materials, a flyer which instructs the member how to go to the Anthem Medicaid website and complete a HRA for each newly enrolled member in the family. In a separate mailing, each new member is mailed a HRA form for completion, with a postage paid return address envelope included. All completed HRA's mailed into the Plan are entered		**Recommendation for Anthem** Anthem should ensure timely outreach to members to facilitate timely completion of HRAs. Anthem should ensure that substance use problems identified by HRAs are assessed and addressed as needed. **Final Review Determination** No change in review determination.	**Anthem Response** **The HRA Policy and Procedure states:** "Upon enrollment with Anthem, a state enrollment file is sent by Corporate Enrollment to the Anthem Document Control Center (DCC), which is responsible for mailing both New Member Packets and Kentucky Adult or Pediatric HRA's to the new member address on file, within five (5) days of receipt. "Thirty (30) days following enrollment, each newly enrolled member who does not have a completed HRA in the CM system will begin receiving Interactive Voice Response (IVR) calls from the IVR vendor (Eliza) for this member outreach process. Eliza will ask the member to complete the HRA telephonically." A revised HRA is in development now. It has been approved by DMS, and will be in production by 7/1/16. The new HRA will have more focused referrals to either Physical Health or Behavioral Health Case Management queues, based upon a point system related to how the member answers questions. For example, question 17 asks "Do you or have you been using drugs or alcohol?". If the member answers "Yes", that answer is scored as 1 point. The new logic triggers a referral to the Behavioral Health CM queue for 1 point on that question.

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	by CM Specialist into the Care Management system using the Kentucky Adult or Kentucky Pediatric HRA assessment form. At any time the CM Nurse or Specialist makes contact with a member, and an HRA is not showing completed in the Case Management System, the CM/CM Specialist will complete the Kentucky Adult HRA with the member. Thirty days following enrollment, each newly enrolled member is who does not have a completed HRA in the Care Management system will begin receiving IVR calls from the IVR vendor for this member outreach process. Eliza will ask the member to complete the HRA telephonically. The following is the sequence of the Eliza calls: Outbound Standard Rules: 2-connects Reach correct person [confirms identity, regardless of whether he continues into the full call]: Goal accomplished Reach non-target person in household [whether they accept or decline message]: Try again at least 2 days later [only if no inbound call in meantime] Reach answering machine: Try at least 2 days later [only if no			

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	<table><tr><td></td><td>inbound call]</td></tr><tr><td>Busy/No Answer</td><td>Maximum of 2 attempts per day, at least 1 hour apart, for up to 3 days</td></tr><tr><td>Wrong Number or Hang Up</td><td>No more outreach attempts</td></tr></table> Upon member completion of a HRA via IVR, the data is uploaded into the Care Management system, populating the KY HRA form. Finally, if a Case Manager or CM Specialist makes an outreach call to a member, and notes that no Kentucky HRA was completed, the HRA questions will be completed during the call with the members' agreement." Excerpt from Anthem HCMS- HRA Final Draft Policy The HRA is only the first screener indicating pregnancy. If a member is identified on the HRA (or via claim review, personal notification) as pregnant, then Warm Health begins outreach right away with a much more detailed prenatal High Risk OB screener. Depending upon the members answers regarding prenatal history, current conditions or issues with this pregnancy the member is automatically sent to either an "Urgent" or "High" OB queue; from that queue the OB Case Manager makes contact attempts within 24 hours (Urgent) or 48 hours (High).			

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Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. The Policy and Procedure was in draft format with no provision for in person assessments. Only 19 files were provided for review. One file for a non-pregnant member did not contain timely follow-up to the initial outreach attempt. The 2 files for pregnant members did not contain an HRA completed within the required 30 days, Anthem should ensure that the Policy and Procedure is updated to address in person assessments. Anthem should submit the final Policy and Procedure to DMS once approved internally. Anthem should ensure that all HRA outreach is timely and is documented for each member.			
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.	Substantial - Anthem's HRA Paper Tool and HRA Call Script include required information. As per the care management logic document provided onsite, this information is used to identify members to triage to various levels of care management. <u>HRA File Review Results</u> HRA file review revealed 10/10 files included the required information. Although logic was provided for HRA responses that trigger care management referral, it was not apparent in any of the files whether members were in need of and/or referred to care management. The MCO provided evidence onsite when requested that one pregnant member with	Substantial	Includes HRA file review results This requirement is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY and the submitted KY HRA Paper Screening Tools, which include demographic and current health and behavioral health status. An algorithm to identify triggers for the need for care management, disease management and other health services based on HRA responses is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY.	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	documented tobacco use and drug use was referred to care management. **Recommendation for Anthem:** The MCO should finalize HRA policy and include required information to be collected in HRAs to ensure appropriate determination of the need for care management or health and community services. Need for and referral to care management should be documented in files. **MCO Response:** The HRA's, once entered into the Case Management system; trigger that member to a CM referral queue if they indicate that they need assistance, or if their answers indicate that they have specific health care needs. A CM Specialist will make outreach attempts to initiate contact, and assist the member as needed, discuss CM options with the member, and task a Case Manager to complete an in-depth assessment if appropriate. This is part of the procedure included in the "HCMS-HRA Final Draft Policy" **Final Review Determination:** No change in review determination. The Policy and Procedure was in draft format. The files did not reflect referral to care management. Anthem should ensure that the Policy and Procedure for HRA is finalized and submitted to DMS. Anthem should ensure that all referrals to care management based on the HRA are documented or otherwise		All completed HRA files (7/7) included required domains of inquiry. In 1/7 completed HRA files, the member indicated pregnancy. On-site staff provided evidence of follow-up OB Screener for this member, which documented that the member was not pregnant. In 2/7 completed HRA files, there was no evidence that identified health issues (tobacco, alcohol/substance) were further assessed, and members who did not have a PCP with whom they worked well (3/7) did not appear to have been further assessed or assisted. While the KY HRA Paper Tools and completed HRAs include queries regarding requests for contact about options for case management, there is no documentation of actual referrals to case management in the files or documentation of whether the member was contacted. **Recommendation for Anthem** Anthem should ensure that issues identified in submitted HRAs are addressed or further assessed. The MCO should ensure that there is a mechanism to document referral to	**Anthem Response** A revised HRA is in development now. It has been approved by DMS, and will be in production by 7/1/16. The new HRA will have more focused referrals to either Physical Health or Behavioral Health Case

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	evident.		or contact by case management so that appropriate follow up is ensured. **Final Review Determination** No change in review determination.	Management queues, based upon a point system related to how the member answers questions. For example, question 17 asks "Do you or have you been using drugs or alcohol?". If the member answers "Yes", that answer is scored as 1 point. The new logic triggers a referral to the Behavioral Health CM queue for 1 point on that question.
The Contractor shall use appropriate healthcare professionals in the assessment process.	Substantial - This requirement is addressed in the 2014 Case Management Program Description, which documents care management assessments by licensed nurses and social workers and sources for identifying members for care management assessments. The draft HRA Policy GBD CM Policy-00X Health Risk Appraisal does not include reference to how members are referred to care management based on HRA responses, and the 2014 Case Management Program Description does not include HRAs as an identification source. **Recommendation for Anthem:** The MCO should include processes and triggers for referrals to care management in a finalized HRA policy, and include the role of HRAs in identifying members for care management in the Case Management Program Description. **MCO Response:** The HRA logic is designed to trigger members who answer select questions with an affirmative to the Case Management queue, where	Full	This requirement is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY and Policy and Procedure GBD CM-008 Use of Non-Clinical Associates in Case Management, which highlights supervision of non-clinical staff by clinical staff and case management activities to be conducted by clinical case management staff, including assessment. The requirement is also addressed in the 2015 Case Management Program Description in Delivery of Case Management Services: Case Management Roles and Functions pages 8-10.	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	then selected for telephone outreach by a Specialist. The Specialist will then identify needs that may be managed in Care Coordination, such as PCP appointments or assistance with prescriptions or refills, or if more complex needs may require further assessment by a Case Manager. See GBD Policy-008 Use of Non-Clinical Associates in Case Management "When the completed HRA is received by the Plan, either electronically, as in the case of the IVR completed HRA's, or on paper for those returned by mail, the information is uploaded or entered into the age-appropriate Adult or Pediatric Kentucky Initial HRA form contained in the Case Management system. Based upon pre-determined system logic, the member information given in the HRA may trigger that individual to system's Case Management queue for outreach and a more detailed assessment. If the HRA indicates that the member is pregnant, the logic will send that file to Warm Health for an OB screener; all pregnant members with an urgent or high risk score resulting from the OB Screener is triggered to the High Risk OB queue in the CM system." Excerpt from Anthem HCMS- HRA Final Draft Policy We will also include the role of HRAs in identifying members for care management in the Case Management Program Description. **Final Review Determination:** No change in review determination. At the time of the onsite review, the documents did not contain the required elements and			

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	the Policy and Procedure GBD Policy-008 Use of Non-Clinical Associates in Case Management was not provided with the pre-onsite documentation or during the onsite review. Anthem should ensure that the Case Management Program Description and the Policy and Procedure for HRA address that HRA information is used to trigger a case management referral when warranted. Anthem should ensure that the revised documents are finalized and submitted to DMS. Anthem should ensure that referrals to case management as a result of the HRA are evident.			
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions, including substance use and mental health disorders.	Minimal - There is no evidence of prompts in the HRA call script for callers to offer assistance for arranging a visit to a PCP, although as per the logic document for HRA calls members without a PCP are referred to care management. <u>HRA File Review Results</u> 3/10 completed HRA files indicated that the member did not have a PCP that they worked well with, yet there was no documentation that the member was offered assistance with arranging a PCP visit. The HRA and HRA call script do not include queries related to needed preventive services. **Recommendation for Anthem:** The MCO should include offering assistance in arranging an initial PCP visit for members in need, and include documented need and assistance offered in HRA files.	Non-compliance	The submitted KY HRA Paper Screening Tools include a query about the member's PCP. Policy and Procedure Health Risk Assessment (HRA)-KY addresses assistance in arranging an initial visit to the PCP for members whose HRA is conducted by a Care Management Nurse or Specialist. As per this document, when the HRA is uploaded into the Case Management system, system logic identifies members to be triggered for further assessment and/or case management. The Policy and Procedure does not address follow up processes for	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: The call script for the HRA is IVR. In the event the member needs assistance, the referral is queued to the CM system for outreach to the member to identify more specifically the need and assist the member with that need. The HRAs, once entered into the Case Management system, trigger that member to a CM referral queue if they indicate that they need assistance, or if their answers indicate that they have specific health care needs. A CM Specialist will make outreach attempts to initiate contact, and assist the member as needed, including to assist with arranging a visit to the PCP, discuss CM options with the member, and task a Case Manager to complete an in-depth assessment if appropriate. This is part of the procedure included in the HCMS-HRA Final Draft Policy. **Final Review Determination:** No change in review determination. The HRA Policy and Procedure was in draft format and the call script did not specifically address assistance with arranging an initial PCP appointment, as is required. The new member must always be offered assistance in arranging an initial PCP whether or not the member requests this. Anthem should ensure that the Policy and Procedure and call script are updated to address assisting all new members with scheduling an initial PCP visit. Anthem should submit the revised documents to DMS once approved internally.		member- submitted completed HRAs (i.e. non-care manager-completed HRAs) that indicate no PCP with whom the member works well. It is not clear from policies how members who submit HRAs indicating lack of appropriate PCPs are outreached and this issue followed up. This lack of clear process was reflected in reviewed files as noted above. **Recommendation for Anthem** The MCO should ensure mechanisms to identify members that are not accessing PCPs, either because they do not have an identified PCP or do not work well with assigned PCP. Members indicating an issue with their PCP on the HRA, regardless of how the HRA is submitted, should have follow up for their concerns. **Final Review Determination** No change in review determination.	**Anthem Response** A revised HRA is in development now. It has been approved by DMS, and will be in production by 7/1/16. This revised Assessment has added the following: **17. May we help you make an appointment with your primary care provider (PCP)?** **Name and contact number of PCP:** If the answer is Yes, this will automatically trigger a referral to the Case Management system queue to assist. The HRA has been revised to reflect the language: "A question on the HRA asks if the member would like assistance with making their initial appointment with their PCP." All members will be offered assistance to make an initial appointment with their PCP by means of the revised HRA, regardless of the means by which it is completed. The HRA P&P was updated and will be submitted

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				to Committee on 3/18/2016. Once approved the P&P will be submitted DMS and DOI.
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.	Full-2015		Includes review of MCO Report #79 Health Risk Assessments	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Health Risk Assessment

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average			**1.83**	

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

Reviewer Decision:

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

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

Final Findings

Health Risk Assessment

Suggested Evidence

Documents

Policies/procedures for:

- Initial health screening assessment (including initial health screening tool)

File Review

File review of a sample of cases selected by the EQRO

Reports

Quarterly reports on the number of new member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals (MCO Report # 79)

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

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.2 Provider Credentialing and Recredentialing				
The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), 907 KAR 1:672 and federal law. The Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Members. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."** The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**" Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Members before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process. If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider enrollment data elements to the Department. A	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department. The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				
Appendix J				
This documentation shall include, but not be limited to:				
defining the scope of providers covered,	Full-2015			
the criteria and the primary source verification of information used to meet the criteria,	Full-2015			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Full-2015			
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.	Full-2015			
Those providers accountable to a formal governing body for review of credentials shall include physicians, dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.	Full-2015			
Providers required to be recredentialed by the	Full-2015			

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.				
The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The Contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.	Full-2015			
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.	Full-2015			
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.	Full-2015			
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall meet requirements under KRS 205.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.				
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;	Full-2015			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Full-2015			
C. A review of the credentialing policies and procedures by the formal body;	Full-2015			
D. A credentialing committee which makes recommendations regarding credentialing;	Full-2015			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Full-2015			
F. Written procedures for the termination or suspension of Providers; and	Full-2015			
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Full-2015		Includes Credentialing file review summary results	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Full-2015			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Full-2015			
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	Full-2015			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Full-2015			
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;	Not Applicable-2015			
F. Previous five (5) years work history;	Full-2015			
G. Professional liability claims history;	Full-2015			
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
I. Current, adequate malpractice insurance, as verified through attestation;	Full-2015			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Full-2015			
K. Documentation of curtailment or suspension of medical staff privileges;	Full-2015			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Full-2015			
M. Documentation of censure by the State or County professional association;	Full-2015			
N. Most recent information available from the National Practitioner Data Bank;	Full-2015			
O. Health and Human Services Office of Inspector General (HHS OIG); and	New Requirement	Full	Addressed in Credentialing Policy, #8, Criteria for Selecting Practitioner – Credentialing Leveling and Committee Presentations, page 2. Anthem also provided a sample provider initial credentialing worksheet that includes results of HHS OIG review.	
P. System for Award Management (SAM).	New Requirement	Full	Anthem provided a sample provider initial credentialing worksheet that includes results of SAM website review. The Credentialing Policy addresses SAM review on pages 10-11.	
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. The ability to perform essential functions of the positions, with or without accommodation;	Full-2015			
B. Lack of present illegal drug use;	Full-2015			
C. History of loss of license and felony convictions;	Full-2015			
D. History of loss or limitation of privileges or disciplinary activity;	Full-2015			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Full-2015			
F. Applicant attests to correctness and completeness of the application	Full-2015			
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;	Full-2015			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Full-2015			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Full-2015			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Full-2015			
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.	Non-Compliance - Anthem states that the site visit form was updated in 2015. This form was not in effect in 2014. **MCO Response:** The site visit form was updated to address this requirement (AKYPEC-0573-15 March 2015) **Final Review Determination:** No change in review determination. The site visit form was not in effect during the review period, CY 2014. The updated form will be compliant for CY 2015. Anthem should ensure that the process is implemented and an evaluation of medical record documentation and record keeping practices at each site is documented.	Minimal	Addressed by Provider Site Visit Form (AKYPEC-0573-15 March 2015). Anthem did not provide evidence of provider monitoring results or follow-up actions. At the onsite review, Anthem reported that provider monitoring has not begun but is planned to coincide with HEDIS data collection in 2016. **Recommendation for Anthem** Anthem should conduct provider monitoring in 2016 and implement follow-up actions in response to findings. **Final Review Determination** No change in review determination.	Medical record reviews have begun. Provider rating and communication will be provided and follow up actions taken.
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be	Full-2015		Includes Recredentialing file review summary results	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:				
A. A current license to practice;	Full-2015			
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Full-2015			
C. A valid DEA number, if applicable;	Full-2015			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Full-2015			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Full-2015			
F. A current signed attestation statement by the applicant regarding:	Full-2015			
1. The ability to perform the essential functions of the position, with or without accommodation;	Full-2015			
2. The lack of current illegal drug use;	Full-2015			
3. A history of loss, limitation of privileges or any disciplinary action;	Full-2015			
4. Current malpractice insurance;	Full-2015			
5. Health and Human Services Office of Inspector	New Requirement	Full	Addressed in Credentialing Policy, #8, Criteria	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
General (HHS OIG);			for Selecting Practitioner – Credentialing Leveling and Committee Presentations, page 2. Anthem also provided a sample provider recredentialing worksheet that includes results of HHS OIG review.	
6. System for Award Management (SAM).	New Requirement	Full	Anthem provided a sample provider recredentialing worksheet that includes results of SAM website review. The Credentialing Policy addresses SAM review on pages 10-11.	
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :	Full-2015			
A. The national practitioner data bank;	Full-2015			
B. Medicare and Medicaid;	Full-2015			
C. State boards of practice, as applicable; and	Full-2015			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Full-2015			
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
treatment centers and clinics.				
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulatory bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.	Full-2015			
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.	Full-2015			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.	Substantial - The Ongoing Sanction Monitoring Policy, Termination Policy, and Policy 12 had procedures for reporting to authorities, however missing from the documentation is specific language referencing the Department. **Recommendation for Anthem:** Anthem should add to its policy language that indicates that the Department is included in its reporting procedures. **MCO Response:** We will add language to our policy that indicates that the Department is included in our reporting procedures.	Substantial	Anthem provided Policy and Procedure Provider Terminations – Primary Care Provider, Specialist and Hospital. This policy/procedure addresses notification of the Department when the Contractor terminates a provider from its network. It does not address notifying the Department of serious quality deficiencies that could result in suspension or termination. During the onsite review, Anthem provided a draft policy, Provider Recruitment and Retention that addresses this requirement on page 4. **Recommendation for Anthem** Anthem should finalize and implement the draft policy.	The policy, Provider Recruitment and Retention, was finalized on 1/25/16 and the process has been implemented.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. Anthem should ensure that the Policy and Procedure is updated accordingly. Anthem should ensure that the updated Policy and Procedure is submitted to DMS.		**Final Review Determination** No change in review determination.	
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.	Full-2015			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Full-2015			
29.1 Network Providers to be Enrolled				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 or as amended and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech therapists, physical therapists, occupational therapists, private duty nursing agencies, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty				

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Groups, Behavioral Health Services Organizations, Certified Family, Youth and Peer Support Providers, Licensed Clinical Social Workers, Targeted Case Managers, and other independently licensed behavioral health professionals. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such enrollment forms as required by the Department. The Department will continue to enroll hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the CASPER/QIES file formally known as OSCAR provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.	Full-2015			
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.	Full-2015			
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.	Full-2015			
29.2 Out-of-Network Providers				
The Department will provide the Contractor with an expected enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.	Full-2015			
29.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.				
29.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.				
29.5 Enrolling New Providers and Providers not Participating in Medicaid				
A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Network but must be enrolled. If a potential Provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of transactions being accepted, suspended or denied. All documentation regarding a provider's qualifications and services provided shall be available for review by	Non-Compliance - This is addressed in the Provider Recruitment and Retention-KY however; it is dated 3/12/15. **MCO Response:** The Provider Recruitment and Retention policy was put into place to address this requirement. **Final review Determination:** No change in review determination. The Policy and Procedure was not in effect during the review period, CY 2014. The Policy and Procedure is compliant for CY 2015. No further action is needed.	Substantial	Policy and Procedure Provider Recruitment and Retention-KY, page 2 addresses requirement for not requiring a provider to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation. This policy does not address the following language: All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice. Addressed on page 2 of draft policy, Provider Recruitment and Retention-KY, provided during the onsite review.	The policy, Provider Recruitment and Retention, was finalized on 1/25/16 and the process has been implemented.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice.			**Recommendation for Anthem** Anthem should finalize and implement the draft policy. **Final Review Determination** No change in review determination.	
29.6 Termination of Network Providers or Subcontractors				
A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members.	Full-2015			
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider within three business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.	Full-2015			
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within 15 days of the action taken if it is a PCP and within 30 days for any other Provider.	Non-Compliance - Anthem referenced its Provider Terminations – Primary Care Provider, Specialist and Hospital policies. However, KY is not addressed in the documentation. An update to the policy was made on 2/24/15. **MCO Response:** The Provider Terminations – Primary Care Provider, Specialist and Hospital policy has been updated to include Kentucky, and approval is in process. **Final Review Determination:** No change in review determination. The Policy and Procedure was not in effect during the review period, CY 2014. Anthem should ensure that the Policy and Procedure is approved and once approved, submitted to DMS.	Full	Addressed in Policy and Procedure Provider Terminations – Primary Care Provider, Specialist and Hospital, page 3.	
B. In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor will provide all terminations monthly, via the Provider Termination Report. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.				
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) 30 days prior to the effective date of the termination or (ii) within 15 days of receiving notice.	Non-Compliance - Anthem referenced its Provider Terminations – Primary Care Provider, Specialist and Hospital policies. However, KY is not addressed in the documentation. An update to the policy was made on 2/24/15. **MCO Response:** The Provider Terminations – Primary Care Provider, Specialist and Hospital policy has been updated to include Kentucky, and approval is in process. **Final Review Determination:** No change in review determination. The Policy and Procedure was not in effect during the review period, CY 2014. Anthem should ensure that the Policy and Procedure is approved and once approved, submitted to DMS.	Full	Addressed in Policy and Procedure Provider Terminations – Primary Care Provider, Specialist and Hospital, page 3.	
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within 15 days of providing notice or (ii) 30 days prior to the effective date of the termination.	Non-Compliance - Anthem referenced its Provider Terminations – Primary Care Provider, Specialist and Hospital policies. However, KY is not addressed in the documentation. An update to the policy was made on 2/24/15. **MCO Response:** The Provider Terminations – Primary Care Provider, Specialist and Hospital policy has been updated to include Kentucky, and approval is in process. **Final Review Determination:** No change in review determination. The Policy and Procedure was not in effect during the review period, CY 2014. Anthem should ensure that the Policy and Procedure is approved and once approved, submitted to DMS.	Full	Addressed in Policy and Procedure Provider Terminations – Primary Care Provider, Specialist and Hospital, page 4.	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	1	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	7	2	1	0
Total Points	21	4	1	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

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

Documents

Policies and Procedures for:

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

Credentialing Committee description, membership, meeting agendas and minutes

Reports

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

File Review

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

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.	Full-2015			
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.	Full-2015			
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;	Full-2015			
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;	Full-2015			
D. Discussing Advance Medical Directives with all Members as appropriate;	Full-2015			
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;	Full-2015			
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and	Full-2015			
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Full-2015			
Maintaining formalized relationships with other PCPs to refer their Members for after-hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Full-2015			
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable arrangements are not implemented:				
A. Acceptable				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;	Full-2015			
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and	Full-2015			
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.	Full-2015			
B. Unacceptable				
(1) Office phone is only answered during office hours;	Full-2015			
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Full-2015			
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Full-2015			
(4) Returning after-hours calls outside of thirty (30) minutes.	Full-2015			
29.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.				
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.	Full-2015			
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:	Full-2015			
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Member residence in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.	Full-2015		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
B. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department in no fewer number than 25% of the Specialists enrolled in the Department's Fee-for-Service program by Medicaid region; and include sufficient pediatric specialists to meet the needs of Members younger than 21 years of age. Access to Specialists shall not exceed 60 miles or 60 minutes. In the event there are less than 5 qualified Specialists in a particular Medicaid region, the 25% shall not apply to that Medicaid region.	Substantial - This requirement is addressed in the Access and Availability Policy as well as in the Geo Access Network documentation. The Geo Access reports and Geo Access Network Quarterly Report meet the requirement. Geo Access Reports Specialists (standard: 1 within 60 miles or 60 minutes) = 100% access Anthem's Geo Access documentation does not break down specialists by specialty. A review of Anthem's Quarterly Desk Audit (Quarter 4, 2014) indicates issues in access to dermatologists in Regions 1 and 6. Access issues pertaining to oral surgeons and orthodontists were being addressed by Anthem's dental vendor at that time, Scion Dental. **Recommendation for Anthem:** It is recommended that Anthem provide Geo Access reports that indicate the requirements and	Substantial	Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results) Policy and Procedure Access and Availability – KY only addresses high-volume specialists. The policy does not address inclusion of 25% of specialists enrolled in the Department's Fee-for-Service program by region. Pediatric specialists are not addressed. Anthem provided a draft Policy and Procedure Access and Availability-KY during the onsite review that addresses this requirement. The 2015 annual Geo Access Network report (12A) reports access to other specialty providers as a category only. (This is consistent with the Report 12A specifications.) For Urban and Rural regions, Anthem reported 100% access. Anthem's quarterly report (October 2015) reports Urban access at 99.8% for high-volume specialists, with 100% access in all counties with the exception of Allen county (88%). Rural access for high-volume specialists was 100%. Anthem's pre-onsite documentation response notes that the report parameters for the quarterly Geo Access reports are being revised to include all participating specialties vs. only high-volume specialties based on utilization. The revised report will move to production during the first quarter of 2016.	The policy, Access and Availability – KY, has been revised to address the requirement of the enrollment of at least 25% of specialists enrolled in the Department's Fee-for-Service program by region. In addition, a new report is in development to monitor this requirement and will be in production during the 2nd quarter 2016. Anthem's internal quarterly Geo Access report has been modified to include all specialists and will be in production for the 1st quarter 2016 reporting period.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	percentages of access for all specialty areas. **MCO Response:** An expanded Geo Access report has been requested to include additional information. **Final Review Determination:** No change in review determination. Anthem should ensure that the Geo Access reports contained the required information regarding specialists.		**Recommendation for Anthem** The draft Policy and Procedure Access and Availability-KY addressing this requirement should be finalized and implemented. In addition, Anthem should provide evidence of monitoring compliance with this requirement. The revised report parameters for the quarterly Geo Access reports should be implemented to include all participating specialties. **Final Review Determination** No change in review determination.	
D. Immediate treatment for any Emergency Medical Services or Emergency Mental Health Disorder or Substance Abuse Disorder Services by a health provider that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Full-2015			
E. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes, except in non-urban areas where access may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.	Full-2015		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 3 weeks for regular appointments and 48 hours for urgent care.	Full-2015		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
G. Access for general vision, laboratory and radiology services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed 30 days for regular appointments and 48 hours for Urgent Care.	Full-2015		Includes review of MCO Report #12A Geo Access Network Reports & Maps(see Quarterly Desk Audit results)	
H. Access for Pharmacy services shall not exceed 60 miles or 60 minutes or the delivery site shall not be further than 50 miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.	Full-2015		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
I. In addition to any Community Mental Health Center or Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program by Medicaid Region to provide out-patient, intensive out-patient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services. In the event there are less than five (5) qualified Mental Health and Substance Abuse providers for both adults and children in a particular Medicaid Region, the fifty (50%) percent shall not apply to that Medicaid Region.	New Requirement	Non-Compliance	Documentation provided does not address this requirement. Anthem's pre-onsite documentation response notes that a new report is being built to compare the number of Medicaid-enrolled mental health and substance abuse providers by region to those contracted by Anthem Medicaid. The report will move to production during the first quarter 2016. Anthem provided a draft Policy and Procedure Access and Availability-KY during the onsite review that addresses this requirement. The quarterly 2015 MCO Report #13, Access and Delivery Network Narrative reports state that Anthem continues to pursue substance use providers and offers assistance to them in obtaining Kentucky Medicaid identification numbers. The Anthem network includes over 1,700 independently licensed behavioral health providers. If services are needed from a	The policy, Access and Availability – KY, has been revised to address the requirement of the enrollment of at least 50% of Mental Health and Substance Abuse providers enrolled in the Department's Fee-for-Service program by region. A new report is in development to monitor this requirement and will be in production during the 2nd quarter 2016.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			provider who is in the credentialing/contracting process, a single case agreement may be completed. The MCO will identify an alternative participating provider or negotiate a single case agreement with a non-participating provider as necessary to ensure access to care. The Q3 report noted one member grievance regarding access to a substance abuse facility. **Recommendation for Anthem** The draft Policy and Procedure Access and Availability-KY should be finalized and implemented. In addition, Anthem should provide evidence of monitoring compliance with this requirement. **Final Review Determination** No change in review determination.	
J. The Department shall notify the Contractor and all other MCOs on contract with the Department when more than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Members to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective members in the Medicaid Region.	New Requirement	Substantial	Anthem's pre-onsite documentation notes that this requirement was discussed during the 11/18/15 DMS/Anthem operations meeting. Per David McAnally, the process is currently being discussed within DMS and that MCOs will have ample time to implement the process upon notification. At the onsite review, Anthem reported that this requirement is discussed during the monthly operational meetings with DMS. Anthem is conducting a related PIP designed to reduce inappropriate ED utilization.	Anthem will draft a policy outlining the process for member outreach and education on alternatives to the Emergency Room.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			A policy and procedure addressing this requirement was not provided. **Recommendation for Anthem** Anthem should develop a policy and procedure detailing the MCO's process for addressing non-emergent visits. **Final Review Determination** No change in review determination.	
29.8 Additional Network Provider Requirements				
A. The Contractor shall attempt to enroll the following Providers in its network as follows:				
1. Teaching hospitals;	Full-2015			
2. FQHCs and rural health clinics;	Full-2015			
3. The Kentucky Commission for Children with Special Health Care Needs; and	Full-2015			
4. Community Mental Health Centers	Full-2015			
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.	Substantial - The requirement is addressed in the Provider Recruitment and Retention Procedure sections 1.i, 5, 6 and 7. However, the policy is in a draft format and was not formally approved during 2014. **Recommendation for Anthem:** It is recommended	Full	Addressed in Policy and Procedure Provider Recruitment and Retention – KY, page 7.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	that Anthem have the Provider Recruitment and Retention Policy formally approved. **MCO Response:** 5/13/15 – Approval for the update to Provider Recruitment and Retention Policy is in process which will address this requirement **Final Review Determination:** No change in review determination. Anthem should ensure that the updated Policy and Procedure is approved and once approved, is submitted to DMS.			
B. In consideration of the role that Department for Public Health, which contracts with the local health departments plays in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:				
1. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.	Full-2015			
2. Provide reimbursement at rates commensurate with those provided under Medicare.	Full-2015			
The Contractor may also include any charitable providers	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
which serve Members in the Contractor Region, provided that such providers meet credentialing standards.				
C. The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.	Full-2015			
29.9 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix L that demonstrates that the Contractor has an adequate network that meets the Department's standards in Section 29.7. The Contractor shall notify the Department, in writing, of any anticipated network changes that may impact network standards herein.	Full-2015		Includes review of MCO Report #12A Geo Access Network Reports & Maps (see Quarterly Desk Audit results)	
The Contractor shall update this information to reflect changes in the Contractor's Network monthly.	Full-2015			
29.10 Expansion and/or Changes in the Network				
If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Members, the Contractor or Department shall notify the other of this situation and within 15 business	Full-2015		Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results)	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
days the Contractor shall submit a corrective action plan to remedy the deficiency. Providers in the Contractor's Network who will not accept Medicaid Members shall not be included in the assessment as to whether the Contractor's Network is adequate to comply with access standard. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.				
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.	Full-2015			
31.1 Medicaid Covered Services				
The Contractor shall provide Covered Services in an the amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program; that are reasonably be expected to achieve the purpose for which the services are furnished; enables the Member to achieve age-appropriate growth and development; and enables the Member to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The contractor may establishing measures that are	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
designed to maintain quality of services and control costs and are consistent with its responsibilities to Members; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.				
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix H shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Full-2015			
The Contractor may provide, or arrange to provide, services in addition to the services described above, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.	Full-2015			
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Full-2015			
If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.	Full-2015			
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.	Full-2015			
33.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).				
33.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in compliance with 42 CFR 438.114.	Full-2015			
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.	Full-2015			
31.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in this contract. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.	Substantial - The requirement is addressed in the Provider Recruitment and Retention Policy. However, the policy is in a draft format and was not formally approved during 2014. **Recommendation for Anthem:** It is recommended that Anthem have the Provider Recruitment and Retention Policy formally approved. **MCO Response:** 5/13/15 – Approval for the update to Provider Recruitment and	Full	Addressed in Policy and Procedure Provider Recruitment and Retention – KY, page 2.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Retention Policy is in process which will address this requirement **Final Review Determination:** No change in review determination. Anthem should ensure that the updated Policy and Procedure is approved and once approved, is submitted to DMS.			
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Full-2015			
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;	Full-2015			
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;	Full-2015			
D. Maternity care for Members under 18 years of age;	Full-2015			
E. Immunizations to Members under 21 years of age;	Full-2015			
F. Sexually transmitted disease screening, evaluation and treatment;	Full-2015			
G. Tuberculosis screening, evaluation and treatment;	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;	Full-2015			
I. Chiropractic services; and	Full-2015			
J. Women's health specialists.	Full-2015			
33.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix H to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.	Full-2015			
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members less than eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.	Full-2015			
All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured	Substantial - The requirement that all information be provided to the member in a confidential manner is addressed in the Provider Manual. The requirement for	Full	Addressed in Policy and Procedure Access and Availability – KY, page 5.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.	appointments for counseling and medical services within 30 days and the requirement for counseling and medical appointments within 10 days for members less than 18 years of age is addressed in the Access and Availability Policy. However, the policy is undated and not formally approved. **Recommendation for Anthem:** It is recommended that Anthem have the Access and Availability Policy formally approved. **MCO Response:** 5/20/15 – Access and Availability policy was approved on 5/18/2015. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure is approved and once approved, is submitted to DMS.			

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Quality Assessment and Performance Improvement: Access

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.17**		

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability
Monitoring of provider compliance with PCP responsibilities
Provider access and availability reports
Geo Access network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care
- Behavioral health services including mental health and substance abuse providers

Final Findings

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

Access and delivery network narrative reports (MCO Report #13)
Evidence of evaluation, analysis and follow-up related to provider program capacity reports
Reports of Out-of-Network Utilization
Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring
Evidence of evaluation, analysis and follow-up related to non-emergent ER visits

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
21.0 Utilization Management				
21.1 Medical Necessity				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health.	Full-2015			
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.	Full-2015			
The description shall include the scope of the program;	Full-2015			
the processes and information sources used to determine service coverage;	Full-2015			
clinical necessity, appropriateness and effectiveness;	Full-2015			
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Full-2015			
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Full-2015			
The UM program shall be evaluated annually, including an evaluation of clinical and service	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
outcomes.				
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director, the Behavioral Health Director, or the Medicaid Commissioner.	Full-2015			
21.2 National Standards for Medical Necessity Review				
The Contractor shall adopt Interqual or Milliman for Medical Necessity; however, the contractor shall adopt the following standardized tools for medical necessity determinations for behavioral health -- for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children; Early Childhood Service Intensity Instrument (ECSII); for substance use: American Society of Addiction Medicine (ASAM).	Full-2015			
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Full-2015			
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.	Full-2015		Includes UM file review results	
The Medical Director and Behavioral Health	Full-2015		Includes UM file review results	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.				
The reason for the denial shall be cited.	Full-2015		Includes UM file review results	
Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.	Full-2015			
The Medical Necessity review process shall be completed within 2 business days of receiving the request and shall include a provision for expedited reviews in urgent decisions.	Full-2015			
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Substantial - MCO provided emails correspondence between Anthem and DMS confirming that individual authorizations do not need to go through DMS, but only changes in overall policy. **Recommendation for Anthem:** MCO should have this requirement in a policy. **MCO Response**: *Added to HCMS Policy and Procedure- Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process *new*	Full	This requirement is addressed in the UM Program Description, Section: Criteria Selection and Implementation, page 11.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Added to the UM Program Description, Section: Criteria Selection and Implementation "Any changes to prior authorization requirements must be approved by DMS." **Final Review Determination:** No change in review determination. Anthem should ensure that the new Policy and Procedure and revisions to the UM Program Description are finalized and approved and submitted to DMS as applicable.			
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.	Full-2015			
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within 3 working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Full-2015			
E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.	Full-2015			
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.	Full-2015			
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Full-2015			
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.	Full-2015			
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Full-2015			
The UM program will be evaluated by the Department on an annual basis.	Substantial - MCO states that the UM Program was submitted to DMS	Full	Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	for review. DMS confirmed receipt as part of the Readiness Review. The Program Description does not reference required annual submission to DMS. **Recommendation for Anthem:** The MCO should add language into its policies and procedures that the UM Program Evaluation is submitted to DMS annually. **MCO Response**: Added to the UM Program Description, Section: "Evaluation of the UM Program" p. 34. **"**annual evaluation of their UM Program, including clinical and service outcomes for medical and for behavioral health, in comparison to program objectives and activities. Results are submitted to the Plan Medical Advisory Committee and Quality Management Committees for review and approval annually, and submitted to DMS annually, as required." **Final Review Determination:** No change in review determination. Anthem should ensure that the new Policy and Procedure and revisions		results) This requirement is addressed in the UM Program Description, Section: Evaluation of the UM Program, page 34. <u>Quarterly Desk Audit Results</u> Q1 2015 - In Q1, the average number of monthly requests was approximately 7,600 per month. The denial rate ranged from 4% to 11%. Dental-Group was the category with the highest number and highest percentage of denials. Q2 2015 - In Q2, the average number of monthly requests was approximately 10,300 per month. The denial rate ranged from 10% to 14%. Dental-Group was the category with the highest number and highest percentage of denials. Q3 2015 - In Q3, the average number of requests was approximately 11,549 per month, a slight increase from Q2. The denial rate ranged from 9% to 11%, which was lower than in Q2. Dental-Group was the category with the highest number and highest percentage of denials, as was the case in Q2 2015. Q4 2015 reporting was not available at the time of this compliance review.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	to the UM Program Description are finalized and approved and submitted to DMS as applicable.			
21.3 Adverse Actions Related to Requests for Services and Coverage Denials				
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any adverse Action (not just service authorization actions) within the timeframes for each type of Action pursuant to 42 CFR 438.210(c). The notice must explain:	Full-2015			
A. The action the Contractor has taken or intends to take;	Full-2015		Includes UM file review results	
B. The reasons for the action in clear, non-technical language that is understandable by a layperson;	Full-2015	Substantial	Includes UM file review results <u>UM File Review Results</u> 8 of 10 files included semi-standardized language in the 2nd paragraph of the denial notice that is unclear. For example," We looked closely at the Pulmicort 1mg/2ml suspension Hendrickson, Robert F. asked for on 8/27/15. looked at all of your data. Based on their decision, we won't pay for the Pulmicort 1mg/2ml suspension." The remaining paragraphs in the notices were more clearly presented however Anthem should review the rationale for the denial decision to ensure member understanding. **<u>Recommendation for Anthem</u>**	**Anthem Pharmacy reviewed the prior authorization case and denial notice dated 8/27/15 for member R.Y.** **Anthem Pharmacy concludes the criteria documented in the system for the PA case of R.Y. was manually inputted erroneously by the Anthem reviewer causing the formatting errors noted by IPRO reviewers.** **The actual notice sent to the member, R.Y., did not have those errors.** **The Anthem Prior Authorization area is aware of the manual formatting error.**

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Reasons for the adverse action should be clearly documented in resolution notices to promote understanding by the member. Standardized language should be assessed for clarity and use of non-technical language. Resolution notices should be monitored regularly for clarity. **<u>Final Review Determination</u>** No change in review determination.	ATM_CAID_KY_Denial_Member_Letter_PA
C. The federal or state regulation supporting the action, if applicable;	Substantial - This was not addressed in any policy. Should be added to the policy. <u>UM File Review</u> 10 of 10 were NA due to the type of denial. **Recommendation for Anthem:** Anthem should add this language to their policy. **MCO Response**: Revised language in policy Healthcare Management Services Denial-Core Process, Exceptions: Kentucky All written notifications of an action include the following: i) Statement of action being taken by the health plan; ii) Explanation of denial reason in easily understood language,	Full	Includes UM file review results This requirement is addressed in the Healthcare Management Services Denial: Core Process, Exceptions, Medicare, Procedures, 8) Notice of Action, page 11. <u>UM File Review Results</u> 6 of 10 files reviewed were NA due to the type of denial. The remaining 4 files were compliant.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	including specific reference to utilization criteria guidelines, protocols or benefits provisions used in the determination; the federal or state regulation supporting the action, if applicable **Final Review Determination:** No change in review determination. Anthem should ensure that the revised Policy and Procedure is approved internally and once approved, submitted to DMS.			
D. The Member's right to appeal;	Full-2015		Includes UM file review results	
E. The Member's right to request a State hearing;	Full-2015		Includes UM file review results	
F. Procedures for exercising Member's rights to Appeal or file a Grievance;	Full-2015		Includes UM file review results	
G. Circumstances under which expedited resolution is available and how to request it;	Full-2015		Includes UM file review results	
H. The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.	Full-2015		Includes UM file review results	
I. Be available in the state-established prevalent non-English languages in its service area;	New Requirement	Full	Includes UM file review results Policy and Procedure Health Care Management – Core Process, page 21 states that the MCO will provide the member with written notice	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			that meets the language and formatting requirements for member materials. Policy and Procedure Medicaid Marketing and Member Communication, page 1 states that marketing and member communications are translated into threshold languages and formats per state contract requirements. A Proposed Notice of Action letter template provided includes notification in English and Spanish that translation services are available. <u>UM File Review Results</u> 10 of 10 files reviewed included language in the resolution notice in English and Spanish that translation services are available.	
J. Be available in alternative formats for persons with special needs; and	New Requirement	Full	Includes UM file review results This requirement is addressed in the Healthcare Management Services Denial: Core Process, Exceptions, Medicare, Procedures, 8) Notice of Action, (c), page 11. <u>UM File Review Results</u> Availability in alternative formats was addressed in the files reviewed.	
K. Be easily understood in language and format.	New Requirement	Full	This requirement is addressed in the Healthcare Management Services Denial: Core Process, Exceptions, Medicare, Procedures, 8) Notice of Action, (c), page 11.	
The Contractor must give notice at least:	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Ten (10) days before the date of an adverse Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.				
B. The Contractor must give notice by the date of the adverse Action for the following:				
1. In the death of a Member;	Full-2015			
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Full-2015			
3. The Member's admission to an institution where he is ineligible for further services;	Full-2015			
4. The Member's address is unknown and mail directed to him has no forwarding address;	Full-2015			
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Full-2015			
6. The Member's physician prescribes the change in the level of medical care;	Full-2015			
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Full-2015			
8. The safety or health of individuals in the facility	Full-2015			

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.				
C. The Contractor must give notice on the date of the adverse Action when the Action is a denial of payment.	Non-Compliance - This language is only in policy Healthcare Management Services Denial - Core Process for Nevada. **MCO Response**: Revised language in policy Healthcare Management Services Denial-Core Process for Kentucky et al, Exceptions: Kentucky *"Anthem will give notice on the date of the Action when the Action is a denial of payment"* **Final Review Determination:** No change in review determination. Anthem should ensure that the revised Policy and Procedure addressing the requirement for Kentucky Medicaid, specifically, is approved internally, and once approved, submitted to DMS.	Full	This requirement is addressed in the Healthcare Management Services Denial: Core Process, Exceptions, Medicare, Procedures, Exceptions-Kentucky, page 20.	
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of	Full-2015		Includes UM file review results	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.				
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.	Non-Compliance - This language is not addressed in policy Healthcare Management Services Denial - Core Process. Language is in document for Virginia page 40. <u>UM File Review</u> 10 of 10 were NA. No denials were on extension. **MCO Response**: Revised language in policy: Healthcare Management Services Denial - Core Process: Exceptions: Kentucky *"A written notice of the reason for the decision to extend the timeframe must be given to the member in writing and inform the Member of the right to file a Grievance if he or she disagrees with that decision. Electronic format, including e-mail or facsimile, may suffice where the member or provider has agreed in advance in writing to receive such notices electronically.*	Full	Includes UM file review results The requirement for notifying the member of the reason for the extension is addressed in the Healthcare Management Services Denial: Core Process, Exceptions, Medicare, Procedures, Exceptions-Kentucky, page 21. Policy and Procedure Clinical Criteria for Utilization Management Decisions – Core Process, page 10 also addresses this requirement as well as the member's right to file a grievance. <u>UM File Review Results</u> 10 of 10 files were NA. No files required an extension.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. Anthem should ensure that the revised Policy and Procedure addressing this requirement for Kentucky Medicaid, specifically, is approved internally, and once approved, submitted to DMS.			
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.	Full-2015			
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action.	Full-2015			
21.4 Prior Authorizations				
The Department on or by January 1, 2016, shall approve a Prior Authorization Form for all participating MCOs, which shall be used by the Contractor to initiate its prior authorization process.	New Requirement	Full	DMS approved the universal Prior Authorization Form in December 2015.	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	9	1	0	0
Total Points	27	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.9**		

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management

Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

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

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
37.0 Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix N, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to 6 months to provide a new or revised program. This plan shall include, at a minimum:	Full-2015			
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;	Full-2015			
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;	Full-2015			
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;	Full-2015			
D. Effective lines of communication between the compliance officer and the organization's employees;	Full-2015			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Enforcement of standards through disciplinary guidelines;	Full-2015			
F. Provision for internal monitoring and auditing of the member and provider;	Full-2015			
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;	Full-2015			
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;	Full-2015			
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Full-2015			
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the Department;	Full-2015			
K. Contractor shall provide procedures for appeal process;	Full-2015			
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2015			
M. Contractor shall create a process for card sharing cases;	Non-Compliance - The documentation submitted by Anthem did not include a process for card sharing cases.	Full	This requirement is addressed in the 2015 SIU Fraud Plan-Kentucky, Alleged Card Sharing Review Process, page 20.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Anthem will incorporate a card sharing process into the Fraud Plan. **Final Review Determination:** No change in review determination. Anthem should ensure that a process for card sharing cases is added to the SIU Fraud Plan and that the revised Plan is submitted to DMS.			
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;	Full-2015		Includes review of MCO Report #75 SUR Algorithms	
O. Contractor shall follow cases from the time they are opened until they are closed; and	Full-2015			
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.	Full-2015			
The plan shall be made available to the Department for review and approval.	Full-2015			
9.2 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the Contractor's enrollment or projected enrollment.				
P. A Compliance Director who shall maintain current knowledge of Federal and State legislation,	Full-2015			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
legislative initiatives, and regulations relating to Contractors and oversee the Contractor's compliance with the laws and requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.				
N. A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's Program Integrity unit to reduce fraud and abuse of Medicaid services.	Full-2015			
38.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Minimal - Anthem corporate parent company, Anthem Kentucky, and all subcontractors who provide services related to claim and/or payment review, Utilization Management (UM) functions (e.g., prior authorization (PA), appeals), coordination of benefits (COB), or provide services directly to members (e.g., dental, vision) were reviewed for submission of Annual Disclosure to Anthem; registration with Kentucky Secretary of State (SOS); and exclusion per the DHHS Office of the Inspector General (OIG) and the US government System for Award Management (SAM) Excluded Parties List System (EPLS).	Minimal	Includes review of individual disclosures This requirement is addressed in the Kentucky State Specific Addenda, Section 14, Additional Requirements, H, i-vii. <u>Individual Disclosure Review Results</u> Anthem corporate parent company, Anthem Kentucky, and all subcontractors (28 subcontractors) who provide services related to claim and/or payment review, Utilization Management (UM) functions (e.g., prior authorization (PA), appeals), coordination of benefits (COB), or provide services directly to	Six of the subcontractors will update their list of Officers on the Kentucky SOS website during their submission of their annual report. The annual report is due no later than 6/30/16. These subcontractors include: - AxisPoint - CulturaLink - DSS Research - Lamont, Hanley and Associates - Pacific Interpreter - Verisk Health

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Annual Disclosure File Review Results 2 of 12 subcontractors were not registered on the Kentucky SOS website: AllMed Healthcare and The Assist Group 2 of 10 subcontractors that were registered did not have Officers listed: DentaQuest and EyeQuest, which belong to the same parent company, DentaQuest Ventures, LLC. 8 of 12 subcontractors did not have Annual Disclosure forms: AllMed Healthcare, The Assist Group, Connolly Consulting and iHealth Technologies (merged), Express Scripts, Health Data Insights (HDI) and Health Management Systems (merged), Optum Insight, Scion Dental. **Recommendation for Anthem:** Anthem should ensure that all applicable subcontractors are registered with the Kentucky SOS; that all registered contractors have Officers registered/listed on the website; and that the MCO obtains Annual Disclosure forms from all applicable subcontractors. Anthem should check the Kentucky SOS website for registration and the exclusions lists for all applicable subcontractors and their officers annually. **MCO Response:** The following process will be implemented to meet the recommendation:		members (e.g., dental, vision) were reviewed for submission of disclosure form to Anthem; registration with Kentucky Secretary of State (SOS); and exclusion per the DHHS Office of the Inspector General (OIG) and the US government System for Award Management (SAM) Excluded Parties List System (EPLS). Anthem and 28 of 28 subcontractors were registered on the KY SOS website. Six of the subcontractors that were registered did not have officers listed: Axis Point; CulturaLink; DSS Research; Lamont, Hanley & Assoc.; Pacific Interpreter Language Line and Versik Health. These 6 subcontractors had recently registered (November/December 2015) on the SOS website and were noted as applying for a certificate of authority. A disclosure of ownership form for Anthem was not provided. One subcontractor did not have a disclosure form: Healthport. 18 subcontractors used the Kentucky designated disclosure form, however, 9 were dated in 2016 and 2 were not dated. 9 subcontractors used a different disclosure form. Two of these were dated in 2016 and one form was not dated.	Anthem will use the Kentucky version of the Disclosure of Ownership form for all contracts. Anthem will verify that all forms are completed and dated. The Disclosure of Ownership form will be completed with the completion of all new contracts and yearly to ensure compliance. All new contracts will be reviewed and verified for registration on the Kentucky SOS website. Annually, prior to 6/30, the Kentucky SOS website will be verified to confirm all subcontractors have submitted their annual report along with the Officers. Healthport did not submit their Disclosure of Ownership to the State. Anthem is currently addressing this compliance concern with the subcontractor.

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	• A notice will be sent to the current subcontractors outlining the recommendation and giving them an established deadline for completion. • If the deadline has passed, the business owner will reach out to the subcontractor to facilitate the completion of the request. (if non-compliant the business owner will take appropriate action) • The recommendation will be part of future subcontractor contracts. An addendum will be completed with any of our current subcontractor if necessary. • A process will be put in place to facilitate the annual review of this recommendation. **Final Review Determination:** No change in review determination. Anthem should ensure that the disclosure process is implemented for all applicable subcontractors, a contract addendum is completed where needed, new subcontractor contract templates include annual disclosure requirements, and that all applicable subcontractors are registered and have complete information on the Kentucky SOS website.		**Recommendation for Anthem** Anthem should ensure that all applicable subcontractors are registered with the Kentucky SOS; that all registered contractors have officers registered/listed on the website; and that the MCO obtains disclosure of ownership forms from all applicable subcontractors. The Anthem disclosure of ownership form should be submitted for review. **Final Review Determination** No change in review determination.	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent,	Minimal – See Above.	Minimal	Includes review of individual disclosures This requirement is addressed in the Kentucky State Specific Addenda, Section H, i. Individual Disclosure Review Results	Anthem will use the Kentucky version of the Disclosure of Ownership form for all contracts. Anthem will verify that all forms are

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
child, or sibling;			A disclosure of ownership form for Anthem was not provided and one subcontractor did not have a disclosure form: Healthport. A total of 27 subcontractor disclosure forms were reviewed. Twenty-four disclosure forms included the required disclosure. Of these, 10 were dated in 2016 and 3 were not dated. Three disclosure forms that were not Kentucky designated forms did not include the required disclosure language (Amerigroup disclosure forms). **Recommendation for Anthem** Anthem should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated. The Anthem disclosure of ownership form should be submitted for review. **Final Review Determination** No change in review determination.	completed and dated. The Disclosure of Ownership form will be completed with the completion of all new contracts and yearly to ensure compliance. Healthport did not submit their Disclosure of Ownership to the State. Anthem is currently addressing this compliance concern with the subcontractor.
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;	Minimal – See Above.	Minimal	Includes review of individual disclosures This requirement is addressed in the Kentucky State Specific Addenda, Section H, ii. Individual Disclosure Review Results A disclosure of ownership form for Anthem was not provided and one subcontractor did	Anthem will use the Kentucky version of the Disclosure of Ownership form for all contracts. Anthem will verify that all forms are completed and dated.

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			not have a disclosure form: Healthport. A total of 27 subcontractor disclosure forms were reviewed. Twenty-four disclosure forms included the required disclosure. Of these, 10 were dated in 2016 and 3 were not dated. Three disclosure forms that were not Kentucky designated forms did not include the required disclosure language (Amerigroup disclosure forms). **Recommendation for Anthem** Anthem should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated. The Anthem disclosure of ownership form should be submitted for review. **Final Review Determination** No change in review determination.	The Disclosure of Ownership form will be completed with the completion of all new contracts and yearly to ensure compliance. Healthport did not submit their Disclosure of Ownership to the State. Anthem is currently addressing this compliance concern with the subcontractor.
C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;	Minimal – See Above.	Minimal	Includes review of individual disclosures This requirement is addressed in the Kentucky State Specific Addenda, Section H, iii. Individual Disclosure Review Results A disclosure of ownership form for Anthem was not provided and one subcontractor did not have a disclosure form: Healthport.	Anthem will use the Kentucky version of the Disclosure of Ownership form for all contracts. Anthem will verify that all forms are completed and dated. The Disclosure of Ownership form will be completed with the completion of all new

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			A total of 27 subcontractor disclosure forms were reviewed. Twenty-three disclosure forms included the required disclosure. Of these, 9 were dated in 2016 and 3 were not dated. Four disclosure forms that were not Kentucky designated forms did not include the required disclosure language. **Recommendation for Anthem** Anthem should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated. The Anthem disclosure of ownership form should be submitted for review. **Final Review Determination** No change in review determination.	contracts and yearly to ensure compliance. Healthport did not submit their Disclosure of Ownership to the State. Anthem is currently addressing this compliance concern with the subcontractor.
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;	Minimal – See Above.	Minimal	Includes review of individual disclosures This requirement is addressed in the Kentucky State Specific Addenda, Section H, iv. Individual Disclosure Review Results A disclosure of ownership form for Anthem was not provided and one subcontractor did not have a disclosure form: Healthport. A total of 27 subcontractor disclosure forms were reviewed. Twenty-four disclosure forms	Anthem will use the Kentucky version of the Disclosure of Ownership form for all contracts. Anthem will verify that all forms are completed and dated. The Disclosure of Ownership form will be completed with the completion of all new contracts and yearly to ensure compliance.

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			included the required disclosure. Of these, 10 were dated in 2016 and 3 were not dated. Three disclosure forms that were not Kentucky designated forms did not include the required disclosure language (Amerigroup disclosure forms). **Recommendation for Anthem** Anthem should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated. The Anthem disclosure of ownership form should be submitted for review. **Final Review Determination** No change in review determination.	Healthport did not submit their Disclosure of Ownership to the State. Anthem is currently addressing this compliance concern with the subcontractor.
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Minimal – See Above.	Minimal	Includes review of individual disclosures This requirement is addressed in the Kentucky State Specific Addenda, Section H, v. Individual Disclosure Review Results A disclosure of ownership form for Anthem was not provided and one subcontractor did not have a disclosure form: Healthport. A total of 27 subcontractor disclosure forms were reviewed and all forms included the required disclosure. Of these, 10 were dated in 2016 and 3 were not dated.	Anthem will use the Kentucky version of the Disclosure of Ownership form for all contracts. Anthem will verify that all forms are completed and dated. The Disclosure of Ownership form will be completed with the completion of all new contracts and yearly to ensure compliance. Healthport did not submit their Disclosure of Ownership to the State. Anthem is currently

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem Anthem should ensure that disclosure of ownership forms are received from all applicable subcontractors; forms include the required disclosures; and are dated. The Anthem disclosure of ownership form should be submitted for review. **Final Review Determination** No change in review determination.	addressing this compliance concern with the subcontractor.
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and	Minimal – See Above.	Full	This requirement is addressed in the Kentucky State Specific Addenda, Section H, vi.	
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.	Full-2015			
State Contract, Appendix N				
ORGANIZATION: The Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct	Full-2015			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
PIU activities and functions specified in this Appendix on a continuous and on-going basis;				
B. Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards;	Full-2015			
C. The unit establishes, controls, evaluates and revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with Federal and State requirements;	Full-2015			
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Full-2015			
E. The unit prioritizes work coming into the unit to ensure that cases with the greatest potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:	Full-2015			
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Full-2015			
(2) High dollar amount of potential overpayment; or	Full-2015			
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Full-2015			
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Full-2015			
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees, or other	Full-2015			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.				
FUNCTION: Contractor and/or Contractor's PIU shall:				
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Full-2015			
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Full-2015			
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Full-2015			
D. Initiate appropriate administrative actions to collect overpayments;	Full-2015			
E. Refer potential Fraud, Waste and Abuse cases to the OIG with copy to the Department for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;	Full-2015			
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside	Minimal - During 2014 Anthem distributed a monthly Fraud Tips to all Anthem Kentucky Medicaid associates. The MSIU Monthly Dashboard & Plan Report was cited as	Full	This requirement is addressed in the FWA Plan, FWA Awareness Program, page 44.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
groups;	evidence, but it was not provided as it was not available in 2014. **Recommendation for Anthem:** FWA newsletters should be distributed to vendors and providers. This regulation should be addressed in a policy. **MCO Response:** The MSIU meets monthly with DentaQuest and ESI; quarterly with eyeQuest to discuss ongoing investigations, schemes, and issues. We receive weekly reports from ESI and monthly reports from DentaQuest & eyeQuest on issues and investigations. As to our network phys., the MSIU will provide an article for publication for each Network Newsletter that is sent to our network phys. FWA Tips are distributed internally to associates and the process is documented in the Fraud Plan. The process for disseminating FWA information to our vendors and providers will also be documented in the Fraud Plan. **Final Review Determination:** No change in review determination. Anthem should ensure that this requirement is incorporated into the SIU Fraud Plan Kentucky. Anthem should submit the revised Plan to DMS once final.			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Anthem should ensure that all vendors and providers receive FWA newsletters/ information.			
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Full-2015			
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Full-2015			
I. Provide for internal monitoring and auditing of Contractor and it subcontractors; and supply the Department with reports on a quarterly basis or as-requested basis on its activity and ad hocs as necessary;	Full-2015			
J. Be subject to on-site review and fully comply with requests from the Department to supply documentation and records;	Full-2015			
K. Create an accounts receivable process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the Department;	Full-2015		Includes review of MCO Report #71 Provider Outstanding Account Receivables	
L. Allow the Department to collect and retain any overpayments if the Contractor has not taken appropriate action to collect the overpayment after 180 days;	Non-Compliance - Anthem stated that "We have not received any notices from DMS that we are to seek overpayments from members. These members would be tracked on Report #72." Even though there were no overpayments,	Full	This requirement is addressed in the Overpayment Policy, page 9.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	there should be a Policy and Procedure to address this. **MCO Response:** We will incorporate the requirement into our existing Overpayments policy. **Final Review Determination:** No change in review determination. Anthem should ensure that this requirement is incorporated into the Overpayment Policy and Procedure. Anthem should ensure that the updated Policy and Procedure is submitted to DMS.			
M. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;	Full-2015			
N. Conduct regular post-payment audits of Provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;	Full-2015			
O. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Full-2015			
P. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Full-2015			
Q. Designate a contact person to work with investigators and attorneys from the Department	Full-2015			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and OIG;				
R. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Full-2015			
S. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Full-2015		Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB)	
T. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;	Full-2015		Includes review of MCO Report #75 SUR Algorithms	
U. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Full-2015			
V. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review and approval;	Full-2015			
W. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Full-2015			
X. Recover overpayments from providers and	Full-2015			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
identify Providers for pre-payment review as a result of the Provider's activities;				
Y. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department; and	Non-Compliance - Anthem did not have a policy in place during 2014 to address this requirement. **MCO Response:** We will incorporate this language into our Fraud Plan. **Final Review Determination:** No change in review determination. Anthem should ensure that this requirement is incorporated into the Fraud Plan. Anthem should submit the updated Fraud Plan to DMS.	Full	This requirement is addressed in the FWA Policy, Exhibit 6 Addendum, page 128.	
Z. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.	Non-Compliance - Anthem did not have a policy in place during 2014 to address this requirement. **MCO Response:** We will incorporate this language into our Plan Compliance Officers policy. **Final Review Determination:** No change in review determination. Anthem should ensure that this requirement is incorporated into the Plan Compliance Officers Policy. Anthem should submit the updated Policy and Procedure to DMS.	Full	This requirement is addressed in the Medicaid Business Unit, Policies and Procedures, Plan Compliance, pages 1-2.	
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately	Full-2015			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reported to the Department for Community Based Services in accordance with state law with copy to the Department and OIG.				
COMPLAINT SYSTEM: The Contractor's PIU shall operate a system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:				
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;	Full-2015			
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Full-2015			
C. If the preliminary inquiry results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments;	Full-2015			
D. If the preliminary inquiry results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the OIG, with a copy to the Department;	Full-2015			
E. OIG will review the referral and attached	Full-2015			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;				
F. If in the process of conducting a preliminary review, the PIU suspects a violation of either criminal Medicaid Fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the OIG with a copy to the Department of their findings and proceed only in accordance with instructions received from the OIG;	Full-2015			
G. If the OIG determines that it will keep a case referred by the PIU, the OIG will conduct a preliminary investigation, gather evidence, write a report and forward information to the Department, the PIU, or, if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate actions;				
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall	Full-2015			

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
suspend Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;				
K. Upon completion of the PIU's preliminary review, the PIU shall provide the Department and the OIG a copy of their investigative report, which shall contain the following elements:	Full-2015			
(1) Name and address of subject,	Full-2015		Includes Program Integrity file review results	
(2) Medicaid identification number,	Full-2015		Includes Program Integrity file review results	
(3) Source of complaint,	Full-2015		Includes Program Integrity file review results	
(4) State the complaint/allegation,	Full-2015		Includes Program Integrity file review results	
(5) Date assigned to the investigator,	Full-2015		Includes Program Integrity file review results	
(6) Name of investigator,	Full-2015		Includes Program Integrity file review results	
(7) Date of completion,	Full-2015		Includes Program Integrity file review results	
(8) Methodology used during investigation,	Full-2015		Includes Program Integrity file review results	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,	Full-2015		Includes Program Integrity file review results	
(10) Attach all exhibits or supporting documentation,	Full-2015		Includes Program Integrity file review results	
(11) Include recommendations as considered necessary, for administrative action or policy revision,	Full-2015		Includes Program Integrity file review results	
(12) Identify overpayment, if any, and recommendation concerning collection,	Full-2015		Includes Program Integrity file review results	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(13) Any other elements identified by CMS for fraud referral;	Full-2015			
L. The Contractor's PIU shall provide the OIG and the Department a quarterly Member and Provider status report of all cases including actions taken to implement recommendations and collection of overpayments, or case information shall be made available to the Department upon request;	Full-2015		Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report	
M. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and	Full-2015			
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Full-2015			
REPORTING: The Contractor's PIU shall report on a quarterly basis in a narrative report format all activities and processes for each investigative case (from opening to closure) to the Department. If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.	Full-2015		Includes review of MCO Report #76 and Report #77	
The Contractor is required to report the following data elements to the Department and the OIG on a	Full-2015		Includes review of MCO Report #76 and Report #77	

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Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
quarterly basis, in an excel format:				
(1) PIU Case number;	Full-2015		Includes review of MCO Report #76 and Report #77	
(2) OIG Case number (if one has been assigned);	Not Applicable-2015		Includes review of MCO Report #76 and Report #77	
(3) Provider/Member name;	Full-2015		Includes review of MCO Report #76 and Report #77	
(4) Provider/Member number;	Full-2015		Includes review of MCO Report #76 and Report #77	
(5) Date complaint received by Contractor;	Full-2015		Includes review of MCO Report #76 and Report #77	
(6) Source of complaint, unless the complainant prefers to remain anonymous;	Full-2015		Includes review of MCO Report #76 and Report #77	
(7) Date opened and name of PIU investigator assigned;	Full-2015		Includes review of MCO Report #76 and Report #77	
(8) Summary of complaint;	Full-2015		Includes review of MCO Report #76 and Report #77	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);	Not Applicable-2015		Includes review of MCO Report #76 and Report #77	
(10) PIU action taken and date (only provide the most current update);	Full-2015		Includes review of MCO Report #76 and Report #77	
(11) Amount of overpayment (if any) and time span;	Full-2015		Includes review of MCO Report #76 and Report #77	
(12) Administrative actions taken to resolve findings of completed cases;	Full-2015		Includes review of MCO Report #76 and Report #77	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(13)The overpayment required to be repaid and overpayment collected to date;	Full-2015		Includes review of MCO Report #76 and Report #77	
(14) Describe sanctions/withholds applied to Providers/Members, if any;	Full-2015		Includes review of MCO Report #76 and Report #77	
(15) Provider/Members appeal regarding overpayment or requested sanctions. List the date an appeal was requested, date the hearing was held, the date and decision of the final order;	Full-2015		Includes review of MCO Report #76 and Report #77	
(16) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented revision and date of implementation; and	Full-2015		Includes review of MCO Report #76 and Report #77	
(17) Make MIS system edit and audit recommendations as applicable.	Full-2015		Includes review of MCO Report #76 and Report #77	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;	Full-2015			
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;	Full-2015			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;	Full-2015			
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or the OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;	Full-2015			
E. Produce records in electronic format for review and manipulation by the Department and the OIG;	Full-2015			
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;	Not Applicable-2015			
G. Provide the Contractor's PIU access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract;	Full-2015			
H. Fully cooperate with the Department, the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or Fraud or Abuse cases; and	Full-2015			
I. Provide identity and cover documents and information for law enforcement investigators under cover.	New Requirement	Full	This requirement is addressed in the FWA Policy, Exhibit 6 Addendum, Program Integrity Availability and Access to Data, (i), page 130.	

Final Findings

Program Integrity

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.08**		

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

Reviewer Decision:

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

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

Final Findings

Program Integrity
Suggested Evidence

Documents

Policies/Procedures for:

- post payment audits
- internal monitoring and auditing
- preventive actions
- annual ownership and financial disclosure

Program Integrity Plan including related policies and procedures
Program Integrity training program and evidence of training for Compliance Officer, staff, providers, subcontractors and members
Program Integrity Unit description including Compliance Officer position description
Program Integrity Committee description and minutes
Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees
Provider contract provisions for FWA
Vendor contract provisions for FWA

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
SUR Algorithms (MCO Report #75)
Quarterly Program Integrity Reports (MCO Reports #76 and 77)
Provider Outstanding Account Receivables (MCO Report #71)
Explanation of Member Benefits (MCO Report #73)

File Review

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

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment				
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix M. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Full-2015		Includes review of MCO Report #93 EPSDT CMS-416 and MCO Report #24	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Full-2015			
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034, and who are supported by adequately equipped offices to perform EPSDT services.	Full-2015			
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these	Full-2015			

Final Findings

services, and the Member's right to access these services.				
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.	Minimal - There was no specific documentation to address informing members, upon enrollment and/or annually, of the right to appeal a decision related to EPSDT services. Appeal of EPSDT services is not specifically addressed in the Policies and Procedures for Appeals and/or Utilization Management (UM), or in the Member Handbook. Onsite staff confirmed that information regarding the right to appeal EPSDT services is not specifically addressed in these documents. <u>EPSDT UM File Review</u> 5 of 5 were compliant. <u>EPSDT Appeal File Review</u> 5 of 5 files were compliant with requirements with the exception of: 0 of 5 files contained evidence that member was informed of the opportunity to examine the case file or present evidence. 0 of 3 applicable resolution letters contained evidence that the member was informed of potential liability for cost of	Substantial	Includes file review results for EPSDT UM files and EPSDT Appeal files The Anthem EPSDT Program Overview for Kentucky Medicaid, v. 2015-2016, section titled Member Outreach, states that the Member Handbook outlines the member's rights and responsibilities, including the right to file an appeal, or review their medical records related to EPSDT services. The Member Handbook addresses EPSDT services in pages 18 and 31, and in the accompanying Health Tips. Page 47 of the Member Handbook advises members of the right to request a medical appeal including EPSDT services. The Member Handbook includes the required information. Policy and Procedure EPSDT Services – Core Policy, page 4 states that member enrollment packets include information regarding EPSDT. Page 4 also notes that members will continue to receive annual notification if they have not utilized EPSDT services. Policy and Procedure EPSDT Corporate Outreach and Monitoring describes the corporate outreach efforts to ensure eligible members receive EPSDT services. Efforts include: preventive health reminder mailings, overdue reminder post cards, and provider notification letters.	

Final Findings

	continued benefits if State Fair Hearing upholds the MCO's decision. 0 of 2 expedited appeal files contained evidence of attempts to provide oral as well as written notification. 0 of 2 expedited appeal files contained evidence that the member/provider was informed of the limited time available to present evidence. **Recommendation for Anthem:** The MCO should inform members of the right to appeal EPSDT services and ensure that required information is included in UM and appeal notification letters and files. **MCO Response:** Appeals resolution letters will be updated in Q2 to reflect the members' rights to examine case files and present evidence as well as the potential liability for cost of continued benefit if the case goes to State Fair Hearing and the MCO's denial is upheld. Specific language will be added to the member handbook in Q2 that informs the member of appeal rights specific to EPSDT and potential liability associated with State Fair Hearing outcomes if the MCO's denial is upheld and will be reflected in an updated version of the **Member Appeals_Core Policy.**		For the current review, Anthem responded that updated Appeal letters were submitted to NextGen, and that final letters were pending. Onsite staff confirmed that approval of the final Appeal resolution letters was still pending. Onsite staff provided a document entitled Grievance and Appeal Process for Medicaid Members that includes potential liability for members if appeal decisions are upheld. The source of this document is not identified; i.e., it is not clear if the document is from the Member Handbook or is an insert for Appeal letters. A review of 5 EPSDT Appeal files revealed that 5/5 files met timeliness standards, with one file demonstrating a request for extension that was appropriately handled. All 5 Appeals were handled by appropriate health care professionals and all 5 resolution letters included appropriate information except for the following: in 2 of 2 applicable cases, the resolution letters did not include information on how to request continuation of benefits and the member's potential liability for cost if the appeal decision was upheld in a State Fair Hearing. **Recommendation for Anthem** Anthem should ensure that the Appeal resolution letters are revised to include how a member can request continuation of benefits and the member's potential liability associated with State Fair Hearing outcomes. **Final Review Determination** No change in review determination.	Appeal letters revised and submitted to CMAP for approval Feb 2015; still under review.

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Final Findings

	Final Review Determination: No change in review determination. Anthem should ensure that upon enrollment, members are informed about EPSDT and the right to appeal any decision relating to Medicaid services, including EPSDT (and are informed annually thereafter when the members have not accessed services during the year). Anthem should ensure that the appeal resolution letters are revised to include the member's right to examine the case file and to present evidence, and the potential liability for cost of continued benefits. Anthem should ensure that for expedited appeals, the member/provider is informed of the limited time to present evidence and attempts are made to provide oral as well as written notification of decision and that these are documented in the expedited appeal file. Anthem should ensure that the Appeals Policy and Procedure is updated to address these requirements. Anthem should submit the revised letters and updated Policy and Procedure to DMS.			
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and	Full-2015			

Final Findings

federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix M.				
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.	Full-2015			
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers shall provide treatment if the service is not available with the Contractor's Network.	Substantial - This requirement is addressed in the Kentucky Medicaid Provider Manual, Corporate EPSDT Services - Core Policy, and the Kentucky EPSDT Provider Toolkit. Information regarding treatment by out-of-network providers does not appear to be specifically addressed in the EPSDT policies. **Recommendation for Anthem:** The MCO should include information regarding treatment by out-of-network providers in the EPSDT Policies and Procedures. **MCO Response:** The Kentucky Medicaid Provider Manual, Corporate EPSDT Services - Core Policy, and the Kentucky EPSDT Provider Toolkit will be updated to specifically reflect out-of-network providers' treatment of members if services are not available within the MCO's network.	Substantial	The Provider Manual notes that precertification is not required for out-of-area/out-of-network care for EPSDT screening. The Anthem Provider Administration of EPSDT Screenings and Special Services for Kentucky Medicaid document, section Screening Provider Participation Requirement addresses provider licensure in Kentucky but does not address in-network vs. out-of-network providers. This document in not dated and it is not clear the intended audience or use of the document. Page 10 addresses services provided out-of-state. The Policy and Procedure Pre-Certification of Requested Services-Core Process indicates that pre-certification is not required for covered EPSDT services provided by Out-of-Network Providers. The EPSDT Program Overview for Kentucky Medicaid, v. 2016-2016, section Provider Information notes that all providers must meet requirements for participation in the Kentucky Medicaid program. The section titled EPSDT Special Services Clinic and Staff addresses out-of-state providers.	Policy: Provider Administration of EPSDT Screenings and Special Services Revised and submitted for Review March 2016. Addition to EPSDT toolkit March 2016

Final Findings

	Final Review Determination: No change in review determination. Anthem should ensure that requirements regarding treatment by OON providers are incorporated into the EPSDT Policies and Procedures. Anthem should submit the updated Policies and Procedures to DMS.		In the pre-onsite documentation provided, Anthem noted that the EPSDT toolkit is under revision to include out-of-network provider information, updated FAQ page, and updated ICD-10 codes. None of the above documents specifically address the use of out-of-state or out-of-network providers when services are not available in the contractor's network. Onsite staff indicated that the updated EPSDT Toolkit is in process, and the update is on the provider portal. **Recommendation for Anthem** Anthem should ensure that requirements regarding treatment by Out-of-Network Providers are incorporated into the EPSDT Policies and Procedures and updated EPSDT Toolkit. **Final Review Determination** No change in review determination.	
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix M.	Minimal - This requirement is addressed in the 2014 EPSDT Program Overview for Kentucky Medicaid, page 4, ESPDT Special Services. The document states that all EPSDT Special Services require prior authorization. A specific policy and procedure for authorization of EPSDT Special Services was not submitted; however, onsite staff indicated that prior authorization requests go to the Medical Director, who indicates if the request is for EPSDT Special	Minimal	The Anthem Provider Administration of EPSDT Screenings and Special Services for Kentucky Medicaid Members document includes a section on "Who can provide EPSDT screenings?" pages 1-3. This document does not address provider qualifications for EPSDT special services or how such providers are identified by the MCO. The EPSDT Program Overview for Kentucky Medicaid, v. 2016-2016 states that all EPSDT Special Services require prior authorization. **Recommendation for Anthem** The MCO should include identifying providers who can deliver Medically Necessary Special	Policy: Provider Administration of EPSDT Screenings and Special Services Revised and submitted for Review March 2016. Provider Manual to be updated.

Final Findings

	Services. Claims submission requirements, including indicators for EPSDT special programs and referrals, are outlined in the Reimbursement Policy (External) Early Periodic Screening Diagnostic and Treatment (EPSDT). Identification of providers who can deliver Medically Necessary EPSDT Special Services is not addressed in policies and procedures. The MCO submitted quarterly Report #38 for 2014, which included the codes, number and cost of EPSDT Special Services provided. **Recommendation for Anthem:** The MCO should develop Policies and Procedures for identifying providers who can deliver Medically Necessary Special Services and for EPSDT Special Services authorization and include this information in the Provider Manual. **MCO Response:** A Policy and Procedure specific for identifying providers who can deliver Medically Necessary Special Services and for EPSDT Special Services authorization will be developed in Q2 and this language will be included in the Provider Manual. **Final Review Determination:** No change in review determination.		Services and for EPSDT Special Services authorization in EPSDT Policies and Procedures and Provider Manuals. **Final Review Determination** No change in review determination.	

Final Findings

	Anthem should ensure that Policies and Procedures to address these requirements are developed and that the Provider Manual is updated accordingly. Anthem should submit the new Policies and Procedures and revised Provider Manual to DMS.			
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.	Minimal - This requirement is addressed in Corporate Policy and Procedure EPSDT Internal Reminder System Data Extract Process and Policy and Procedure EPSDT Corporate Outreach and Monitoring. Anthem provided a sample Excel file from its tracking database. The MCO tracks services due and services received. Onsite staff indicated that refusals are tracked, but these do not appear in the same tracking database. There did not appear to be a field for EPSDT Special Services in the file. The MCO provided counts of Special Services in Report #38. This shows that Special Services are tracked, but Member-specific tracking of need for and receipt of EPSDT Special Services was not demonstrated. The Policies and Procedures submitted do not address tracking of refusals and member-specific receipt of EPDST Special Services.	Substantial	Anthem provided Policy and Procedure EPSDT Provider Tracking. This document is not dated and no policy number is assigned. The policy's purpose is to evaluate PCP adherence to EPSDT requirements and establish a process to educate PCPs who consistently fail to complete timely screenings. The policy references an EPSDT audit tool that was not provided with the pre-onsite documentation. Policy and Procedure EPSDT Corporate Outreach and Monitoring describes the corporate outreach efforts to ensure eligible members receive EPSDT services. Efforts include: preventive health reminder mailings, overdue reminder post cards, and provider notification letters. Anthem provided screen shots from the Member Provider Outreach Portal (MPOS) database, which allows tracking of member outreach, outcome of outreach, and receipt of EPSDT services. There is documentation of opt-in status, but it does not appear to be specific to EPSDT services. Onsite staff provided screenshots of EPSDT Member 360, which includes a care summary with alerts, eligibility, claims, utilization, pharmacy, lab, care management notes, communications and documents. Authorizations, diagnoses, and description of	EPSDT data of refusals loaded into MPOS system Policy: Provider Administration of EPSDT Screenings and Special Services Revised and submitted for Review March 2016. Policy: Health Plan Quality Management Medical Records Requirement; revised and submitted Mar 2016

Final Findings

	Recommendation for Anthem: The MCO should ensure that EPSDT services, including Special Services, need for receipt of and refusals are tracked for each eligible Member individually. **MCO Response:** Anthem will begin utilization of the MPOS system (Member/Provider Outreach System) to log outreach calls to members in need of EPSDT services. Within this outreach system, refusals will be documented and can be reported on. A designated Outreach Specialist position has been approved and is to be hired and trained within Q3 2015. **Final Review Determination:** No change in review determination. Anthem should ensure that a single tracking system is established and maintained to monitor receipt, acceptance and refusal of EPSDT services, necessary diagnosis and treatment, and EPSDT Special Services when needed.		services received are included in the tool. It is not clear from these screen shots whether refusals and EPSDT Special Services can be tracked. **Recommendation for Anthem** The MCO should ensure that EPSDT Special Services and member refusals of EPSDT services are tracked. Anthem should include processes for tracking of members' receipt of needed EPSDT services in Policies and Procedures. **Final Review Determination** No change in review determination.	
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when	Substantial - The 2014 EPSDT Program Overview Kentucky Medicaid contains information on care management services as they relate to EPSDT on page 4, Case Management Services. EPSDT Services are also generally addressed in the 2014 Kentucky UM Program Description and in the EPSDT Coordinator	Full	This requirement is addressed in the Case Management Program Description, section Coordination of Care, page 20.	

Final Findings

recommended assessments and treatment are not received.	Responsibilities document. Assistance with scheduling and transportation is addressed in the 2014 EPSDT Clinic Days Program Guide. The Case Management Program Description does not specifically mention EPSDT services, scheduling, and transportation. **Recommendation for Anthem:** Anthem should include identifying gaps in preventive care/EPSDT services and assisting/facilitating obtaining these services for members in its care management Policies and Procedures. **MCO Response:** The case management program description will be updated for 2015 to address assisting eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received. In addition, policies will be updated to reflect this procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the			

Final Findings

	Case Management Program Description and Policies and Procedures are updated to incorporate these requirements. Anthem should submit the updated Program Description and Policies and Procedures to DMS.			
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.	Minimal - This requirement is addressed in the Policy and Procedure Corporate EPSDT Corporate Outreach and Monitoring, which states that Corporate Clinical Quality Management (CCQM) Department gathers, tracks, trends and monitors member and provider reports and information and uses the data to monitor EPSDT rates and identify outreach opportunities for members and providers. In addition, the MCOs are capable of monitoring outreach activity. The sample Excel file from the tracking database does not appear to contain the following required fields: dates of contact, appointments and rescheduling, follow-up on referral compliance, reports from referral providers. Onsite staff indicated that this information is tracked by the Corporate office. **Recommendation for Anthem:** The MCO should maintain a consolidated record so that required information can be	Full	Anthem provided screen shots from the Member Provider Outreach Portal (MPOS) database, which partially address this requirement. Onsite staff provided a screenshot EPSDT Member 360, which is a consolidated record of member care and includes claims, utilization, pharmacy, labs, medical equipment, authorizations, care management, communications and other documents. The Care Management page includes assessment, problems, and care plans. Anthem provided Policy and Procedure EPSDT Provider Tracking. This document is not dated and no policy number is assigned. The policy's purpose is to evaluate PCP adherence to EPSDT requirements and establish a process to educate PCPs who consistently fail to complete timely screenings. The policy references an EPSDT audit tool that was not provided with the pre-onsite documentation or onsite.	

Final Findings

	tracked for each eligible member and the MCO can ensure that each member receives needed services. **MCO Response:** Anthem will begin utilization of the MPOS system (Member/Provider Outreach System) to log outreach calls to members in need of EPSDT services. Within this outreach system, refusals will be documented and can be reported on. A designated Outreach Specialist position has been approved and is to be hired and trained within Q3 2015. **Final Review Determination:** No change in review determination. Anthem should ensure that a consolidated EPSDT record with the required information is established for each eligible member, including: reports about EPSDT, information from providers, dates of contact regarding EPSDT screening, recommended services, follow-up on compliance, and reports from providers.			
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.	Full-2015			

Final Findings

Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.	Full-2015			
K. Participate in any state or federally required chart audit or quality assurance study.	Full-2015			
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.	Substantial - This requirement is addressed in 2014 EPSDT Program Overview Kentucky Medicaid, page 6, Provider Information, though with the exception of PCPs, the specific provider types referenced in the contract are not specifically mentioned (e.g., medical residents, specialists, nurse practitioners, registered nurses and physician assistants). The EPSDT services and assessments, Special Services, and emerging health issues are addressed in the EPSDT Provider Tool Kit, EPSDT Quick Reference Guide, EPSDT Resources list, EPSDT Assessment Summary (Kentucky-specific), and sample EPSDT provider cover letter. The MCO submitted a training PowerPoint presentation entitled Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Program Overview for Kentucky Medicaid and an EPSDT Provider Contact	Substantial	The Provider Administration of EPSDT Screenings and Special Services for Kentucky Medicaid Members document, page 11 describes a Kentucky EPSDT Provider Toolkit as being distributed to all providers. A web portal is available and updated periodically with pertinent information, resource guides and additional educational materials. On-site training is also available. Nurse practitioners, nurses and physician assistants are listed as providers that conduct medical screenings, including physical exams. This document includes specific requirements for these providers. Medical residents are not specifically addressed. Documentation provided does not specifically address MCO training for physical assessment procedures for medical residents, nurse practitioners, nurses and physician assistants who provide EPSDT services. Evidence of training materials or training attendance records was not provided. Onsite staff provided an undated Policy and Procedure EPSDT Provider Tracking. Tracking of medical residents and specialists are included in this document. Educational modalities listed in this document include site visits. This	Policy: Provider Administration of EPSDT Screenings and Special Services Revised and submitted for Review March 2016. Provider Manual updated

Final Findings

	Letter that indicates tools and education regarding EPSDT services are available to providers. There was no evidence submitted regarding specific training for assessment procedures for nurse practitioners, nurses and physician assistants who provide EPSDT services. As per onsite staff, this training has not yet been provided. **Recommendation for Anthem:** The MCO should develop and present training for assessment procedures for nurse practitioners, nurses and physician assistants who provide EPSDT services. **MCO Response:** Training for assessment procedures for nurse practitioners, nurses and physician assistants who provide EPSDT services will be developed and presented in 2015. This format will be similar to that of training for providers specific to MDs. **Final Review Determination:** No change in review determination. Anthem should ensure that EPSDT training for nurse practitioners, nurses and physician assistants are developed and delivered.		document also refers to reporting of rates by PCP annually. Onsite visits for EPSDT education have been conducted, as per onsite staff. Documentation of these visits was not provided. **Recommendation for Anthem** Anthem should include training for medical resident in Policy and Procedures, and track training initiatives for PCP providers, such as site visits or presentations and training for providers with suboptimal screening rates. **Final Review Determination** No change in review determination.	

Final Findings

M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.	Full-2015			
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Full-2015			
23.1 Required Functions				
N. The Contractor's Member Services function shall also be responsible for: Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.	Full-2015			
38.9 EPSDT Reports				
The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter File shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.	Full-2015		Includes review of MCO Report #93 EPSDT CMS-416	

Final Findings

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	2	4	1	0
Total Points	6	8	1	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

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

Documents

Policies/procedures for:

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

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

Reports

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

File Review

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

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.	Full-2015		Includes review results for each subcontractor	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Full-2015		Includes review results for each subcontractor	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.	Full-2015		Includes review results for each subcontractor	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Full-2015		Includes review results for each subcontractor	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.	Full-2015		Includes review results for each subcontractor	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.	Full-2015			

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors for the provision of Covered Services, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.	Full-2015		Includes review results for each subcontractor	
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.	Full-2015		Includes review results for each subcontractor	
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management,	Full-2015		List subcontractors contracted with the MCO and type of services provided	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
or otherwise interact with a Member. Such Subcontractors must be eligible for participation in the Medicaid program as applicable. Each such Subcontract and any amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontractors within ten (10) days following termination.				
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;	Full-2015		Includes review results for each	

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Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			subcontractor	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Full-2015		Includes review results for each subcontractor	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Full-2015		Includes review results for each subcontractor	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Full-2015		Includes review results for each subcontractor	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Full-2015		Includes review results for each subcontractor	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Full-2015		Includes review results for each subcontractor	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Full-2015		Includes review results for each subcontractor	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	Full-2015		Includes review results for each subcontractor	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;	Full-2015		Includes review results for each subcontractor	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the	Full-2015		Includes review results for each subcontractor	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department's specifications required by this Contract;				
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,	Full-2015			
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,	Full-2015		Includes review results for each subcontractor	
(2) all QAPI requirements,	Full-2015		Includes review results for each subcontractor	
(3) all record keeping and reporting requirements,	Full-2015		Includes review results for each subcontractor	
(4) all obligations to maintain the confidentiality of information,	Full-2015		Includes review results for each subcontractor	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,	Full-2015		Includes review results for each subcontractor	
(6) all indemnification and insurance requirements, and	Full-2015		Includes review results for each subcontractor	
(7) all obligations upon termination;	Full-2015		Includes review results for each subcontractor	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;	Full-2015		Includes review results for each subcontractor	
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.	Full-2015		Includes review results for each subcontractor	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Full-2015		Includes review results for each subcontractor	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Full-2015		Includes review results for each subcontractor	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Full-2015		Includes review results for each subcontractor	
The requirements would be applicable to Subcontractors characterized as Risk Arrangements. The requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services to Members.	Full-2015			
6.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any	Non-Compliance - Anthem submitted a	Full	Addressed in Policy and Procedure	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.	document, Disclosure of Subcontractors, in which they stated that they have no disclosures to report for 2014. This is addressed in Systems for Ensuring Subcontractor's Administrative and Financial Capacity to Meet Contractual Obligations; however, it was not in place during 2014. **MCO Response:** Policy has been updated for 2015. **Final Review Determination:** No change in compliance level. The Policy and Procedure is compliant for 2015. No further action is needed.		System for Ensuring Subcontractor's Administrative and Financial Capacity to Meet Contractual Obligations, page 4.	

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

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

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

Documents

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

Reports

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

IPRO
Improving Healthcare for the Common Good

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

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
35.2 Care Management System				
As part of the Care Management System, the Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.	Full-2015			
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms	Full-2015		Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results)	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
that may be utilized by the Contractor.				
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.	Full-2015			
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Full-2015			
35.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Full-2015			
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Full-2015			
The Contractor shall identify a Member with special physical and behavioral health care needs and shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs	Full-2015			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.				
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.	Full-2015		Includes review results for Care Coordination and Complex Case Management files	
The Care Plan shall be developed in accordance with 42 CFR 438.208.	Full-2015		Includes review results for Care Coordination and Complex Case Management files	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.	Non-Compliance - Addressed in Policy and Procedure DCBS – Foster Care Children; however, this is a draft policy that was not approved in 2014. Could not find evidence that the MCO shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.	Non-Compliance	This requirement is addressed in Policy and Procedure DCBS – Foster Care Children; however, this is a draft policy on initial submission. Onsite staff confirmed that this Policy and Procedure was approved January 11, 2016, and provided the approved Policy and Procedure for review. Policy and Procedure Coordination of Care Between Behavioral Health and Medical Management and Policy and Procedure Coordination of Care Between Physical and Behavioral Health Care Providers address care coordination for members with co-occurring medical and behavioral health conditions. This policy is not specific to	• Anthem will develop a PCP/Behavioral Health Specialist Provider coordination letter to be faxed or mailed to a member's PCP and/or Behavioral Health Provider. This letter will be used for any member enrolled in a BH Case Management Program, and will be sent after consent to release to the PCP and/or behavioral Health Provider is obtained from the member and/or guardian. To be developed and in production by July 1, 2016. • The above mentioned letter will identify any current providers known to the Anthem Foster Care Liaison and will encourage coordination between the

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for Anthem: Anthem should ensure that in 2015, the Policy and Procedure is approved and implemented. Anthem should ensure that in 2015, indicators of utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population are measured, tracked, analyzed, reported, and when indicated, corrective actions are developed and implemented. **MCO Response:** Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy and Procedure to ensure access to coordination of care is approved internally and once approved, submitted to DMS. Anthem should ensure that measurement of indicators that		DCBS members. Policy and Procedure Identification and Assessment of Individuals with Special Healthcare Needs (ISHCN) – KY addresses Anthem's procedure for identifying and assessing members with special healthcare needs, including DCBS clients. As evidence of tracking, analyzing, and reporting indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population, Anthem provided MCO Reports #65, 38 and 103. For MCO Report #65, Anthem provided the report business requirements, not actual reports. Reports #38 and 103 were not provided. MCO reports showing CM status and DMCCU status were provided, as well as tracking of members open in case management over time, and average IP admissions per month over time. It is not evident that these reports refer to DCBS members. Another report shows various graphs related to case load by CI3 group, admissions for cases currently open and cases recently closed, and ER visits for	providers (upon consent of the member), specifically the importance of notification of medication changes and significant changes in the members treatment plan(s). • All Anthem DCBS Members enrolled in a Behavioral Health Complex Case Management program with the Foster Care Liaison will have a completed comprehensive assessment, which includes a review of care coordination needs. Monthly Audits by the Anthem Corporate Performance Improvement Team (PIE) team began in January for Complex Case Management cases. The audit includes indicators related to Assessment Care Coordination and PCP communication. The audits scores are calibrated and reviewed monthly with the PIE team, CM Leadership; and the Performance Enhancement team. The first three month of audits (i.e., Jan, Feb, March) for Kentucky are an initial audit period to establish a baseline regarding weaknesses and strengths of the Foster Care Liaison. Routine Audits will begin in April 2016. Monthly Audits along with review of performance will continue throughout 2016. • Anthem will develop a provider communication to be sent to all in

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	measure utilization, access, complaints and grievances, and satisfaction specific to the DCBS population is completed and actions taken where warranted.		cases currently open and cases recently closed. As noted above, it is not evident that these reports refer to DCBS members. How Anthem tracks, analyzes, reports, and when indicated, develops corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population was discussed onsite. Onsite staff did not provide evidence of tracking specific to the DCBS population. As per onsite file review results detailed below, it was not clear that active DCBS clients could be reliably identified or that receipt of EPSDT services was being tracked. Onsite staff indicated that were ongoing discussions between the Anthem Case Management and DCBS, but documentation of these discussions were not provided. **Recommendation for Anthem** Anthem should ensure that the Policy and Procedure to ensure access to coordination of care is submitted to DMS and implemented.	network providers on the importance of care coordination and integration of physical health and behavioral health related to members/patients. Anthem will develop and implement an on line provider meeting/training related to care integration. September 2016. • Anthem will also identify and track DCBS member grievance and dis-enrollment requests via monthly grievance and dis-enrollment reports. • Anthem will identify, track, analyze and report DCBS members' utilization via DMS Regulatory Report 38. • Anthem will accurately identify and track DCBS members active involvement in Case Management via DMS Regulatory Report 65. • Anthem will measure satisfaction of DCBS members monthly during monthly meetings with DCBS and DMS in addition to applicable member satisfaction surveys.

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Anthem should ensure that measurement of indicators that measure utilization, access, complaints and grievances, and satisfaction specific to the DCBS population is completed and actions taken where warranted. **Final Review Determination** No change in review determination.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.	Full-2015			
36.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in	Full-2015			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.				
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.	Full-2015			
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.	Full-2015			
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; individuals with chronic behavioral health illnesses; and children receiving EPSDT Special Services.	Minimal - Addressed in Policy and Procedure CM-017 Case Management of Persons with Special Needs, on pages 2-3, which states "Sources for identification of members with special needs" and lists numerous sources of identification including providers, case managers, claims data and authorizations. On page 2, the types of members that comprise the ISHCN population are described. Addressed in the Provider Manual, Section 4.3 Members	Minimal	Includes review of MCO Report #20 Utilization of Subpopulations and ISHCN (see Quarterly Desk Audit results) Policy and Procedure Identification and Assessment of Individuals with Special Healthcare Needs (ISHCN) – KY addresses all required populations. <u>Quarterly Desk Audit Results</u> Q1 2015 – <u>Guardianship Members</u> Anthem reported 11 new guardianship members in Q1. No new guardianship members were enrolled in case management or disease management. One member completed an HRA. At the end of	**The 2014 recommended changes were made to the Case Management Program Description.** **In addition, there is a newly developed enrollment report which identifies:** • Children in/or receiving Foster Care or adoption assistance; • Guardianship members • Related Populations eligible for SSI; • Adults over the age of 65; • Homeless (upon identification); **Individuals with chronic medical or behavioral conditions are identified via our CI3 report.** **The Policy and Procedure: "Identification and**

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	with Special Needs pages 39-40 meets the requirement. Addressed in Anthem Medicaid Case Management Program Description, Identification, Screening and Grouping on pages 12-18, which describes the process used to identify members appropriate for CM services; however, the document does not specifically mention "identifying ISHCN members including Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; individuals with chronic behavioral health illnesses; and children receiving EPSDT special services." Addressed in Policy and Procedure Care Management/Complex Care Management, Definition section, "Individuals with Special		Q1 (March 2015), Anthem reported 42 existing guardianship members. One existing member was enrolled in case management and none were enrolled in disease management. One member had an HRA completed. <u>Foster Care/Out of Home Placement Members</u> Anthem reported 39 new foster care members in Q1. Four new foster care members were enrolled in case management and none were enrolled in disease management. Ten new members complete an HRA. At the end of Q1 (March 2015), Anthem reported 49 existing foster care members. 39 existing members were enrolled in case management. No existing members were enrolled in disease management. Five existing members completed an HRA. Anthem reported participation in state meetings and direct provider engagement for behavioral health outreach activities. Q2 2015 – <u>Guardianship Members</u> Anthem reported 34 new guardianship members in Q2. Seven new guardianship members were enrolled in case management and none were enrolled in	**Assessment of Individuals with Special Healthcare Needs" was approved in 12/2015.**

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Healthcare Needs (IHSCN)" which are defined as "members who have or are at high risk for chronic physical, developmental, behavioral, neurological or emotional condition and who require a broad range of primary, specialized medical, behavioral health and/or related services" but does not specifically include "Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; individuals with chronic behavioral health illnesses; and children receiving EPSDT special services." The 2014 Quarterly Desk Audit results of Report #20 Utilization of Subpopulations and ISHCN results included: Q1 - Guardianship Members Anthem reported 2 new guardianship members in Q1. Neither completed an HRA or		disease management. Three new members completed an HRA. At the end of Q2 (June 2015), Anthem reported 86 existing guardianship members. 26 existing members were enrolled in case management and none were enrolled in disease management. Nine existing members had an HRA completed. Foster Care/Out of Home Placement Members Anthem reported 52 new foster care members in Q2. Four new foster care members were enrolled in case management and none were enrolled in disease management. Ten new members complete an HRA. At the end of Q2 (June 2015), Anthem reported 73 existing foster care members. Six existing members were enrolled in case management. No existing members were enrolled in disease management. Eight existing members completed an HRA. Anthem reported participation in state meetings and direct provider engagement for behavioral health outreach activities, including DCBS and DAIL meetings. Q3 2015 – Guardianship Members Anthem reported 81 new guardianship members in Q3. Of those, 27 were enrolled	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	was enrolled in CM or DM. At the end of Q1 2014, Anthem reported 2 existing guardianship members, neither of which completed an HRA or was enrolled in CM or DM. Foster Care/Out of Home Placement Members Anthem reported no new foster care members in Q1. At the end of Q1 2014, Anthem reported 0 existing foster care members. Comments – None Q2 - Guardianship Members Anthem reported one new guardianship member in Q2, who did not complete an HRA and was not enrolled in CM or DM. At the end of Q2 2014, Anthem reported 0 existing guardianship members. The MCO reported recurring meetings with DAIL. Foster Care/Out of Home Placement Members Anthem reported no new foster care members in Q2. At the end of Q2 2014, Anthem reported 0 existing foster care members. Anthem reported recurring meetings with DCBS.		in case management, none were enrolled in disease management, and 5 completed an HRA. At the end of Q3 (September 30, 2015), Anthem reported 26 existing guardianship members with none enrolled in case management, none enrolled in disease management, and 2 completed an HRA. Foster Care/Out of Home Placement Members Anthem reported 71 new foster care members in Q3 with 1 of those enrolled in case management, none were enrolled in disease management, and 5 complete an HRA. At the end of Q3 (September 30, 2015), Anthem reported 104 existing foster care members, with none enrolled in case management, 1 enrolled in disease management, and none completed an HRA. Q4 2015 – Q4 reports were not available at the time of the review. After review of Q2 reports, IPRO sent the following comment to Anthem: Anthem should report on progress of receiving service plans from DCBS and DAIL. Anthem response: DCBS Regional MCO liaisons are emailing service plans to Anthem Foster Care Liaison. Foster Care	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Comments – None Q3 - Guardianship Members Anthem reported 13 new guardianship members in Q3. No new guardianship members completed an HRA or were enrolled in MC or DM. At the end of Q3 2014, Anthem reported 0 existing guardianship members. Foster Care/Out of Home Placement Members Anthem reported 13 new foster care members in Q3. At the end of Q3 2014, Anthem reported 12 existing foster care members. Two existing members completed an HRA and 1 was enrolled in CM. The MCO reported coordination of behavioral health activities with DCBS. Comments - For Report #20, Anthem should report: the total number of Guardianship members and Foster Care members enrolled at the end of the quarter, the number of service plans received for each population and the number of members in each population enrolled in case management.		Liaison has monthly contact with each DCBS MCO Liaison and DCBS management to discuss progress of the obtaining service plans. Currently Anthem has approximately 75% foster care DCBS case plans. Guardianship case plans are provided by Regional DAIL Supervisors. Guardianship Liaison has monthly contact with Regional Supervisors and DAIL management to review progress of obtaining case plans. Anthem Medicaid currently has approximately 70% of Guardianship case plans. Onsite staff indicated ongoing work on coordinating with DCBS for receipt of service plans. Quarterly Report 20 documents outreach efforts for homeless populations. Although Anthem reported access to 75% of DCBS case plans and 70% of Guardianship plans, Quarterly Reports appear to indicate that many Foster Care and Guardianship members are not assessed by HRA or engaged in Case Management or Disease Management. Onsite staff indicated that DCBS members were enrolled in Case Management per DCBS request. It is not clear from submitted files that DCBS members can be reliably identified, and it	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Q4 - Guardianship Members Anthem reported 23 new guardianship members in Q4. One new member completed an HRA and none were enrolled in CM or DM. At the end of Q4 2014, Anthem reported 35 existing guardianship members. Six existing members completed an HRA and none were enrolled in CM or DM. Foster Care/Out of Home Placement Members Anthem reported 35 new foster care members in Q4. At the end of Q4 2014, Anthem reported 32 existing foster care members. No existing members completed an HRA or were enrolled in CM or DM. The MCO reported coordination of behavioral health activities with DCBS. Comments: For Report #20, Anthem should report: the total number of Guardianship members and Foster Care members enrolled at the end of the quarter, the number of Service Plans received for each population and the number of		is not clear that members receiving EPSDT Special Services can be identified. **Recommendation for Anthem** Anthem should ensure that potentially high risk/high need members with Special Health Care Needs, such as Children in/or receiving Foster Care or adoption assistance and those members receiving EPSDT Special Services can be identified and are assessed for Special Health Care Needs. **Final Review Determination** No change in review determination.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	members in each population enrolled in case management. **Recommendations for Anthem:** The MCO should add the contract language to the relevant Policies and Procedures. For Report #20, the MCO should report: the total number of Guardianship members and Foster Care members enrolled at the end of the quarter, the number of Service Plans received for each population and the number of members in each population enrolled in case management. **MCO Response:** Anthem will add the contract language to the relevant Policies and Procedures. For Report #20, we will report: the total number of Guardianship members and Foster Care members enrolled at the end of the quarter, the number of Service Plans received for each population and the number of members in each population			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	enrolled in case management. Plan – Contract language will be added to policies and procedures (drafts, draft revisions ready to be sent to policy / procedure committee) and include above data in Report #20 for 2015 Q2 data and going forward. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policies and Procedures are updated and once updated, submitted to DMS. Anthem should ensure that Report #20 is revised per the recommendations.			
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.	Substantial - The Plan provided copies of the following education materials available to ISHCN members: Coronary Artery Disease, Heart Conditions, HIV/AIDS, Hypertension, Lung Conditions, Major Depressive Disorder, Asthma, and Diabetes. **Recommendation for Anthem:**	Substantial	Policy and Procedure Member Education describes Anthem's procedure for documenting member participation in education events, such as mailings, face-to-face outreach, etc. Anthem provided education materials available to ISHCN members: Coronary Artery Disease, Heart Conditions, HIV/AIDS, Hypertension, Lung Conditions and Major Depressive Disorder.	**Educational materials are available for distribution to members with Special Healthcare Needs, and new materials can be identified as we identify the prevalence of various behavioral and medical conditions specific to our populations.** **In 2016 we will analyze our data to identify the prevalence of various conditions among Foster Care members. Using this data, we will develop**

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
	The MCO should consider creating educational materials specific to the needs of foster children, such as materials focusing on obtaining needed preventive services, and materials that address conditions that are prevalent in that population, such as common child behavioral health conditions (e.g., ADHD, developmental disabilities). **MCO Response:** Anthem will consider creating educational materials specific to the needs of foster children, such as materials focusing on obtaining needed preventive services, and materials that address conditions that are prevalent in that population, such as common child behavioral health conditions (e.g., ADHD, developmental disabilities). Plan – BH to conduct workgroup with member services and provider relations in July 2015 to review enhanced communication		A brochure provided by the Commission for Children with Special Health Care Needs was provided and describes programs available to eligible members by the Commission. Per the 2014 Quality Management Program Evaluation, guidelines are also in place for: Asthma, Diabetes, Hypertension in Children and Adolescents, Family Planning, Obesity in Children, Child Preventive Health, Immunizations, BH Screening, Bipolar Adolescent, ADHD, Substance Abuse and Schizophrenia. These guidelines are applicable to foster children, however evidence of educational materials based upon these guidelines was not provided. Anthem also provided a screenshot from its CareCompass Healthwise Knowledgebase, which includes disease-specific and population-specific materials. Member educational materials websites were presented to advocacy groups at QMAC meetings. Onsite staff reported providing resources for advocacy groups and presentation regarding DCBS. Evidence for conduct of	**specific educational materials to address.**

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	and education outreach efforts, as well as coordinating with DCBS Central Office and the DBHDID regarding outreach and educational opportunities that align with both departments current initiatives. **Final Review Determination:** No change in review determination. Anthem should ensure that information and materials specific to the needs of ISHCN are created and distributed to members as necessary.		these presentations was not provided. **Recommendation for Anthem** The MCO should evaluate prevalent special health care needs of members, including chronic conditions and conditions prevalent among foster children. The MCO should consider developing materials for foster children, such as materials focusing on obtaining needed preventive services, and materials that address conditions that are prevalent in that population, such as common child behavioral health conditions (e.g., ADHD, developmental disabilities). Anthem should ensure that information and materials specific to the needs of ISHCN are created and distributed to members and caregivers as necessary. **Final Review Determination** No change in review determination.	
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Full-2015			
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	Full-2015			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.	Full-2015			
36.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.	Substantial - Addressed in Policy and Procedure DCBS – Foster Care Children and Policy and Procedure Adult Guardianship Members; however, both are draft policies that were not approved in 2014. Evidenced in Report #65, which is used by the MCO to report Foster Care cases to the state on a monthly basis. Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 10 files were reviewed. 10 of 10 files contained referral to CM. 10 of 10 files were compliant	Non-compliance	Includes review results for DCBS Service Plans and DCBS Claims/Case Management files; however, DCBS Service Plans were not reviewed for 2016. Anthem provided Policy and Procedure DCBS – Foster Care Children and Policy and Procedure Adult Guardianship Members; however, both were approved January 11, 2016. Although a case listing for DCBS members in case management was requested, the selected sample did not include any members engaged in case management and many members were former DCBS clients rather than active DCBS clients. There were only 4 applicable files of the 12 files in the sample list, i.e. DCBS clients, although it did not appear that any were engaged in ongoing care management. The remaining cases were former DCBS clients	• Adult Guardianship and Foster Care Policies and Procedures approved and implemented 1/11/2016.

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	with the requirements for care plans. 10 of 10 files were compliant with requirements for ongoing care coordination. 10 of 10 files were compliant with the requirement for monthly meetings with DCBS. <u>DCBS Claims/Care Management File Review Results</u> 10 files were reviewed. 1 of 10 files contained evidence of a PCP visit. 2 of 10 files contained evidence of EPSDT services. 2 of 8 files without EPSDT services had evidence of outreach. **Recommendation for Anthem:** Anthem should ensure that in 2015, the Policy and Procedure is approved and implemented for the entire contract period. Anthem should make efforts to obtain Service Plans from DCBS for its enrolled DCBS/Foster and DAIL members and ensure that the Service Plans, when available,		who were older than 18 years. <u>File review result for DCBS Service Plan files</u> Among 4 files of DCBS clients, none were referred for case management. Of the 4 applicable files, one file included an HRA but no care coordination. The member was noted to have behavior problems on a prior placement. One other file included coordination to obtain an appropriate Medicaid card (no assigned PCP) for the member so that a PCP could be accessed. There was evidence of continued, persistent effort by Case Manager to resolve this issue. Referral providers for Impact Plus-like services were forwarded to DCBS for this member. This member had documented exposure to violence and various behavior and psychiatric issues, and on placement immunizations were unknown. There was no further evidence of care coordination for this member. The other 2 files included no evidence of care coordination. One of the files indicated that outreach was attempted prior to placement, but the member could	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	are used to determine if the member should be enrolled in case management. For DCBS clients not in case management, the MCO should ensure ongoing care coordination, including ensuring routine PCP well visits, receipt of EPSDT services, and follow-up/outreach to members who do not have PCP visits and/or EPSDT services. **MCO Response:** Anthem will ensure that in 2015, the Policy and Procedure is approved and implemented for the entire contract period. Plan – effective date of all policies and procedures sent to policy and procedure committee will have effective date 1/1/2014. Anthem will make concentrated efforts to obtain Service Plans from DCBS for its enrolled DCBS/Foster and DAIL members and ensure that the Service Plans are signed by an MCO representative and are used to		not be contacted. Despite physical and psychiatric problems, there was no indication of care coordination after placement. The other case was a member with developmental issues and no EPSDT claims, but there was no outreach documented. Only 1 of the 4 files included evidence of a PCP visit, and no other EPSDT services were documented. Notably, among the former DCBS clients there were multiple issues noted, such as multiple ED visits and substance abuse. **Recommendation for Anthem** Anthem should ensure that DCBS clients can be appropriately identified, and that policies approved in 2016 are implemented. Anthem should ensure that for DCBS clients not in case management, the MCO should ensure ongoing care coordination, including routine PCP visits for well visits, receipt of EPSDT services, and follow-up/outreach to members who do not have PCP visits and/or EPSDT services. Although not required for this element in	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	determine if the member should be enrolled in case management. Plan – PER DMS COMMUNICATION DATED 5/22/2015: Regarding service plans and any contract compliance issues with MCOs and DCBS/DAIL members: There is not a place for the MCOs to sign on the 106B (service plan) for either DCBS or DAIL members. The MCO should not be penalized for this on compliance reviews. DCBS would have to alter their "master" form in order for MCOs to be compliant with the signature. Every month, all five MCOs meet with DCBS and DAIL. Service plans are a standing agenda item for those meetings. Every MCO requests missing service plans, monthly, during those meetings and at other times by directly contacting the caseworkers. During those meetings, MCOs regularly provider reports as to how many members they have enrolled including statistics regarding case management.		the contract, Anthem could consider evaluating former DCBS clients for potential care coordination needs, as this may represent a high risk group. **Final Review Determination** No change in review determination.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	For DCBS clients not in case management, the MCO should ensure ongoing care coordination, including routine PCP visits for well visits, receipt of EPSDT services, and follow-up/outreach to members who do not have PCP visits and/or EPSDT services. Plan – Anthem will enroll all DCBS members we are notified of or via routine membership runs (I.e. member detail tabs of reports 65 and 66) to identify new DCBS and DAIL members as well as current utilization of PCP services, ensuring that state guardians are aware of potential service gaps if no PCP or no utilization of PCP services identified on newly identified DCBS/DAIL members. **Final Review Determination:** The review determination is changed to substantial based the following: Submission of Report #65 Full compliance with the file			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	review requirements for care management of DCBS clients. Minimal compliance with the file review for receipt of PCP/EPSDT services and follow-up/outreach. The Policies and Procedures were not effective in 2014.			
36.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.	Non-Compliance - Addressed in Policy and Procedure Adult Guardianship Members; however, this is a draft policy that was not approved in 2014. Upon discussion with DMS, review of Service Plans is not applicable. **Recommendation for Anthem:** Anthem should ensure that in 2015, the Policy and Procedure is approved. The MCO should make efforts to obtain Service Plans for DAIL members and, when available, use the Service Plans to make decisions on the need for case management.	Non-compliance	Policy and Procedure Adult Guardianship Members was provided in draft form pre-onsite. This Policy and Procedure addresses the requirement, but it was not approved until January 11, 2016. **Recommendation for Anthem** Anthem should ensure implementation of Policy and Procedure Adult Guardianship Members, which was approved on January 11, 2016. **Final Review Determination** No change in review determination.	• Adult Guardianship Policy and Procedure implemented and effective 1/11/2016.

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval. **Final Review Determination:** No change in review determination. Anthem should ensure that in 2015, the Policy and Procedure is approved.			
36.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.	Substantial - Addressed in Policy and Procedure DCBS – Foster Care Children; however, this is a draft policy that was not approved in 2014. Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 10 files were reviewed. 10 of 10 files contained referral to CM.	Not Applicable	Includes review results for DCBS Service Plans files, but review of DCBS Service Plans was not required for 2016. Policy and Procedure DCBS – Foster Care Children was provided and includes all requirements; however this policy was not approved until January 11, 2016. The MCO does meet monthly with DCBS. File review for DCBS Service Plans not required for 2015.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	10 of 10 files were compliant with the requirements for care plans. 10 of 10 files were compliant with requirements for ongoing care coordination. 10 of 10 files were compliant with the requirement for monthly meetings with DCBS. **Recommendation for Anthem:** Anthem should ensure that in 2015, the Policy and Procedure is approved. **MCO Response:** Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval. **Final Review Determination:** The review determination is changed to Substantial, based on the following: Full compliance with the file review requirements for care		**Recommendation for Anthem** Anthem should ensure implementation of Policy and Procedure Foster Care Children, which was approved on January 11, 2016.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	management of DCBS clients. The Policies and Procedures were not effective in 2014.			
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.	Substantial - Addressed in Policy and Procedure DCBS – Foster Care Children; however, this is a draft policy that was not approved during 2014. Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 10 files were reviewed. 10 of 10 files contained referral to CM. 10 of 10 files were compliant with the requirements for care plans. 10 of 10 files were compliant with requirements for ongoing care coordination. 10 of 10 files were compliant with the requirement for monthly meetings with DCBS. **Recommendation for Anthem:** Anthem should ensure that in	Not Applicable	Includes review results for DCBS Service Plans files, but file review for DCBS Service Plans was not required for 2015. Policy and Procedure DCBS – Foster Care Children was provided; however this policy was not approved until January 11, 2016.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	2015, the Policy and Procedure is approved. **MCO Response:** Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval. **Final Review Determination:** The review determination is changed to Substantial, based on the following: Full compliance with the file review requirements for care management of DCBS clients The Policies and Procedures were not effective in 2014. Anthem should make efforts to obtain Service Plans from DCBS for its enrolled DCBS/Foster and ensure that the Service Plans, when available, used to determine if the member should be enrolled in case management.			

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Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	Substantial - Addressed in Policy and Procedure DCBS – Foster Care Children; however, this is a draft policy that was not approved in 2014. Upon discussion with DMS, review of Service Plans is not applicable. <u>DCBS Service Plan File Review Results</u> 10 files were reviewed. 10 of 10 files contained referral to CM. 10 of 10 files were compliant with the requirements for care plans. 10 of 10 files were compliant with requirements for ongoing care coordination. 10 of 10 files were compliant with the requirement for monthly meetings with DCBS. **Recommendation for Anthem:** Anthem should ensure that in 2015, the Policy and Procedure is approved. **MCO Response:** Anthem will	Not applicable	Includes review results for DCBS Service Plans files; however, DCBS Service Plans files were not reviewed for 2015. Policy and Procedure DCBS – Foster Care Children was provided; however this policy was not approved until 2016. Onsite staff indicated that Case Management discussed each case with DCBS, although evidence documenting these discussions was not provided. File review for DCBS Service Plans were not required for 2015. There were no documented case management care plans for the 4 applicable DCBS Claims/Case Management files.	

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Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval. **Final Review Determination:** The review determination is changed to Substantial, based on the following: Full compliance with the file review requirements for care management of DCBS clients. The Policies and Procedures were not effective in 2014.			
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department	Not Applicable-2015			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.				
33. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.	Minimal - Addressed in Policy and Procedure Reporting Suspected Abuse, Neglect and/or Domestic Violence of Children and Adults. The policy addresses the responsibility of the Case Management staff to report all cases of suspected abuse. Addressed in reporting Suspected Child, Elder, Partner Abuse Procedure Kentucky, on page 8, "The contract, at section 32.9, Pediatric Sexual Abuse Examination, requires that "Contractor shall have Providers in its network that has the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS."" Draft Policy and Procedure Provider Recruitment and	Full	Policy and Procedure Provider Recruitment and Retention – KY, page 3 addresses this requirement.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Retention-Kentucky, Section 3.0 states that providers in the MCO's network include "Child Advocacy Centers able to perform pediatric sexual abuse examination." This policy was not approved in 2014. **Recommendation for Anthem:** Anthem should ensure that in 2015, the Policy and Procedure is approved. **MCO Response:** These areas will be addressed by policy draft, adoption and implementation. Policy drafted in 2015 will be adopted and implemented. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy is approved and once approved, submitted to DMS.			
33.8 Pediatric Interface				
School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.				

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.	Non-Compliance - The MCO did not submit any documentation in support of the requirement. The MCO reported that it is revising the EPSDT Core Policy and Procedure to include exception language but this documentation was not made available for review during Pre-Onsite and Onsite document review. **Recommendation for Anthem:** The MCO should develop, approve and implement a Policy and Procedure to ensure that school-based services are excluded from coverage, services provided by the Department of Public Health in schools are covered services, IEP services are not duplicated, and medically necessary services are provided by the MCO during school breaks. **MCO Response:** This policy will be drafted, adopted, and implemented, by the Health plan. **Final Review Determination:** No	Full	Anthem pre-onsite documentation referred to Policy and Procedure Pediatric Interface-School Based Services. This policy was provided onsite for review. The Policy was approved 12/2/15 and addresses this requirement.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	change in review determination. Anthem should ensure that the Policy is developed, approved and once approved, submitted to DMS and implemented.			
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.	Non-Compliance - The MCO did not submit any documentation in support of the requirement. **Recommendation for Anthem:** The MCO should develop, approve and implement a Policy and Procedure to ensure that services provided by HANDS are excluded from coverage. The MCO should develop, approve and implement a Policy and Procedure to ensure that pediatric concurrent care, as mandated by the ACA, including palliative hospice services, curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses are provided and covered.	Full	Anthem pre-onsite documentation refers to Policy and Procedure Pediatric Interface-Concurrent Care. This policy was provided onsite; it is dated 12/11/15 and addresses the requirement.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Both policies will be drafted, adopted and implemented, by the Health plan. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policies are developed, approved and once approved, submitted to DMS and implemented.			
38.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.	Minimal - MCO Reports #65 Foster Care Report and #66 Guardianship Report, both monthly reports, show the number of new & existing members within the population; however, the reports do not state the number of Service Plan reviews conducted, outcome decisions and rationale for decisions. The reports provide the number of members that were referred to case management. **Recommendation for Anthem:** The MCO should ensure that MCO Reports #65 Foster Care	Full	Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results) See quarterly desk audit results provided above under Section 36.1. Q4 reports were not available for this review.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Report and #66 Guardianship Report, both monthly reports, show all required information, including: the number of new & existing members within the DCBS and DAIL populations, the number of service plan reviews conducted, outcome decisions and rationale for decisions. **MCO Response:** Anthem will ensure that MCO Reports #65 Foster Care Report and #66 Guardianship Report, both monthly reports, show all required information, including: the number of new & existing members within the DCBS and DAIL populations, the number of service plan reviews conducted, outcome decisions and rationale for decisions. The reports provide the number of members enrolled in case management programs. Plan – BH department will work with Enterprise Reporting regarding solutions to include all necessary data in reports 65 and 66, which incidentally have been			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	switched to quarterly reports as of Feb 2015 per DMS communications. **Final Review Determination:** No change in review determination. Anthem should ensure that Reports #65 and #66 are updated to include all required information.			

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Case Management/Care Coordination

Scoring Grid:

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

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average			1.67	

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

Reviewer Decision:

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

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

Final Findings

Case Management/Care Coordination

Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

Reports of service plan reviews conducted for DCBS and DAIL clients (MCO Reports #65 and 66)
HRAs (MCO Report #79)
Utilization of Subpopulations and ISHCN (MCO Report #20)

File Review

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

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.7 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.	Full-2015			
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Substantial - This is addressed in the Provider Manual; section 3, pages 34-37. The MCO stated that the Provider Manual is accessible to in and out-of-network providers via the MCO's website https://mediproviders.anthem.com/Documents/KYKY_CAID_ProviderManual.pdf which is an open document available to the general public. In 2015, the MCO revised section 2.9 in the Provider Manual to include the following language: "Policies & procedures covering the authorization of services may be made available to any out-of-network provider upon request by calling Anthem at 1-855-661-2027." **Recommendation for Anthem:** Language that addresses copies of the Policies and Procedures to be	Substantial	This is addressed in section 3.15 on pages 33-36 of the Provider Manual for network providers. The 2015 Provider Manual does not address that copies of the policies and procedures are to be provided to any out-of-network providers upon request from the provider. The 2016 Provider Manual addresses provision of prior authorization policies and procedures to out-of-network providers. The requirement to provide policies and procedures related to member rights and responsibilities is not included. **Recommendation for Anthem** The Provider Manual should be revised to include the provision of policies and procedures related to member rights and responsibilities to out-of-network providers upon request. **Final Review Determination**	Section 2.9 – Out-of-Network Providers- of the Provider Manual has been updated to capture this requirement for out-of-network providers.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	provided to any Out-of-Network Provider upon request from the Provider should be added to the Provider Manual. **MCO Response:** The Provider Manual has been updated for 2015 to include the required language. **Final Review Determination:** No change in review determination. The requirements were not addressed by the Provider Manual during the review period, CY 2014. Anthem should ensure that the updated Provider Manual is submitted to DMS.		No change in review determination.	
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;	Full-2015			
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Full-2015			
C. Consent for or refusal of treatment and active participation in decision choices;	Full-2015			
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;	Full-2015			
F. Timely access to care that does not have any communication or physical access barriers;	Full-2015			
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Full-2015			
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Full-2015			
I. Timely referral and access to medically indicated specialty care; and	Full-2015			
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Full-2015			
K. Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to receive services from that provider if part of Contractor's network.	New Requirement	Full	This requirement is addressed on page 57 of the Member Handbook.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Full-2015			
B. Abide by the Contractor's and Department's policies and procedures;	Full-2015			
C. Become informed about service and treatment options;	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Actively participate in personal health and care decisions, practice healthy life styles;	Full-2015			
E. Report suspected Fraud and Abuse; and	Full-2015			
F. Keep appointments or call to cancel.	Full-2015			
23.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.	Full-2015			
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.	Minimal - The Cultural and Educational Needs Policy and Procedure does not address the Kentucky requirement that the Member Handbook be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population. The Member Handbook page 2 instructs members to call the Plan "If you want to ask for a copy of this Member Handbook in a preferred language" but it does not specify the languages. The MCO noted that the required	Full	This requirement is addressed in the President's welcome message on the introductory page of the Member Handbook, specifying "We also translate written materials into languages spoken by more than five (5) percent of the enrollee or potential enrollee population, including Spanish." This is further addressed on page 57 of the Member Handbook, specifically "Member handbooks are also available in any language spoken by five (5) percent of the enrollee or potential enrollee population, including Spanish". It also instructs members to call Member Services to obtain a copy of the Member Handbook in the language or format of their choice.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	wording was added to the Member Handbook in 2015. **Recommendation for Anthem:** The required language should be included in the Member Handbook. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. The Member Handbook was not compliant during the review period, CY 2014. Anthem should ensure that the required updates are added to the Member Handbook and that the updated Handbook is submitted to DMS.			
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Full-2015			
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	Full-2015			
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
following information:				
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;	Full-2015			
B. The procedures for selecting a PCP and scheduling an initial health appointment;	Full-2015			
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;	Full-2015			
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;	Full-2015			
E. Member rights and responsibilities including reporting suspected fraud and abuse;	Full-2015			
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Full-2015			
G. Procedures for obtaining transportation for both emergency and non-emergency situations;	Full-2015			
H. Information on the availability of maternity, family planning and sexually transmitted disease services and	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
methods of accessing those services;				
I. Procedures for arranging EPSDT for persons under the age of 21 years;	Full-2015			
J. Procedures for obtaining access to Long Term Care Services;	Full-2015			
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Full-2015			
L. A list of direct access services that may be accessed without the authorization of a PCP;	Full-2015			
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;	Full-2015			
N. Information about how to access care before a PCP is assigned or chosen;	Minimal - No documentation was provided that addresses how a member can access care before a PCP is assigned or chosen – see Your Providers pages 6-11. The MCO stated that they have an open network. The member can choose any PCP provider or any specialist in the network (with a referral) that is in the Plan's network. The member can use the Plan's website Anthem.com or call Member Services to find a provider. A PCP is assigned within 30 days of enrollment.	Full	This requirement is addressed within the President's welcome message on the introductory page of the Member Handbook, as well as on pages 5 and 6 of the Member Handbook, instructing members to call Member Services if members need care before they receive their ID cards.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The MCO referred to policy and procedure AKY-MEM-0018-13 KY ID Card and ID Card Letter_ Copy for Layout with Dual ID Card Letter_12-3-13_Rebrand but this policy was not provided for review. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. The Member Handbook was not compliant during the review period, CY 2014 and the referenced Policy and Procedure was not provided. Anthem should ensure that the required updates are added to the Member Handbook and that the updated Handbook is submitted to DMS.			
O. A Member's right to obtain second opinion in or out of the Contractor's Provider network and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;	Full-2015			
P. Procedures for obtaining Covered Services from non-network providers;	Full-2015			
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Grievances and Appeals;				
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Full-2015			
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Full-2015			
T. Information on the availability of health education services;	Full-2015			
U. Information deemed mandatory by the Department; and	Non-Compliance - Documentation to address this requirement was not submitted by the MCO. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. No documentation was provided and the Member Handbook was not compliant during the review period, CY 2014. Anthem should ensure that the required updates are added to the Member Handbook and that the updated Handbook is submitted to DMS.	Full	This requirement is addressed on pages 57-58 of the Member Handbook. The MCO has added the following language: "Anthem provides information deemed mandatory by the Department of Medicaid Services" and has included a list of all mandatory information required by the Department.	
V. The availability of care coordination, case management and disease management provided by the Contractor.	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
31.3 Second Opinions				
At the Member's request, the Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, or arrange for the Member to obtain a second opinion outside the network without cost to the Member. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Full-2015			
23.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.	Full-2015		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).				
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.	Full-2015		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.	Substantial - The Provider Manual addresses the availability of interpreter services at no cost to the member. Cultural competency training is also available to providers. The Member Handbook addresses interpreter services at no cost to the member, availability of the Member Handbook in the member's preferred language, in large print, Braille and for hearing impaired members. Policy and Procedure Cultural Competency specifies that MCO staff must be able to respond to the special communication needs of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations and that the MCO shall provide ongoing training to staff and Providers on meeting	Full	This requirement is addressed within the President's welcome message on the introductory page of the Member Handbook, as well as on page 5. From the President's welcome message: "For members who do not speak English, we offer free oral interpretation services for all languages. We also translate written materials into languages spoken by more than five (5) percent of the enrollee of potential enrollee population, including Spanish. If you would like this handbook in a different language or format, please call Member Services." This requirement is further addressed on page 5: "We can provide this handbook in: Another language; a large-print version; an audiotaped or CD version; a Braille version." This requirement is also addressed within the Provider Manual, Section 5.8, on page 46: "At no cost to the provider or member,	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	the needs of economically disadvantaged and culturally diverse individuals. Policy and Procedure Cultural and Educational Needs and Cultural Competency does not address the Kentucky requirement that the Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population. The MCO stated that the requirement that "the Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population" language was added to the Member Handbook in 2015. **Recommendation for Anthem:** The MCO should add this language to the Member Handbook and provide to members. **MCO Response:** Member Handbook and P&P have been updated with required language. **Final Review Determination:** No change in review determination.		interpreter services are available to members who are hearing impaired or are non-English speaking. Information about language and translation services is available by contacting Anthem Member or Provider Services." Cultural competency training is available for providers as well. Policy and Procedure Cultural Competency – KY was provided onsite and addresses this requirement.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The Member Handbook and the Policy and Procedure were not compliant during the review period, CY 2014. Anthem should ensure that the required updates are made to the Member Handbook and the Policy and Procedure and that these are submitted to DMS.			
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.	Minimal - The Provider Manual addresses the American with Disabilities Act (ADA) requirements but does not address cooperation with the Cabinet for Health and Family Services' ombudsman program including providing immediate access to a member's records when written consent is provided. The Member Handbook addresses how members may contact the Cabinet for Health and Family Services' ombudsman program but does not address ADA requirements. **Recommendation for Anthem:** These requirements should be added to the Member Handbook. **MCO Response:** Member Handbook and Provider Manual have been updated with required	Full	The Provider Manual, page 11, addresses federal and state requirements including the Americans with Disabilities Act (ADA) requirements pertaining to access to provider sites. The Provider Manual addresses cooperation with the Cabinet for Health and Family Services in regard to providing members' records upon request. The Member Handbook addresses the ADA requirements on page 11. The MCO added the following language: "All Anthem Blue Cross and Blue Shield Medicaid provider offices are required to comply with applicable federal, state and local laws, including ADA. These locations must provide adequate space, supplies, sanitation and fire and safety procedures applicable to health care facilities." The Member Handbook also addresses how members may contact the Cabinet for Health and Family Services.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	language. **Final Review Determination:** No change in compliance level. The Provider Manual and Member Handbook did not address the requirements during the review period, CY 2014. Anthem should ensure that the necessary updates to the Manual and Handbook are made and these are submitted to DMS.			
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Substantial - Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is responsible for these functions. Page 2 of Member Handbook states that members can contact Member Services to discuss member rights and responsibilities. Policy and Procedure Member Services Function addresses the requirements but was not updated to address the Kentucky requirements until March 2015. **Recommendation for Anthem:** It	Full	Both the Member Handbook and the Provider Manual outline the member rights and responsibilities. On page 2 of the Member Handbook, there is a list of items members can call Member Services about, including their rights and responsibilities. The Provider Manual, section 3.15 page 33, states "Our Member Services representatives serve as member advocates." Policy and Procedure Member Services Functions addresses that Member Services is responsible for this requirement.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	should be noted in the Member Handbook that these services are provided by Member Services. **MCO Response:** Member Handbook submitted contains required. **Final Review Determination:** No change in review determination. The language in the Member Handbook on page 2 is acceptable; however, the Policy and Procedure and Provider Manual did not address the requirements during the review period, CY 2014. Anthem should ensure that the necessary updates to the Policy and Manual are completed and both are submitted to DMS.			
B. Ensure each Member is free to exercise his or her rights without the Contractor or its Providers treating the Member adversely.	New Requirement	Substantial	This requirement is addressed on page 59 of the Member Handbook. The Provider Manual does not address this requirement. The manual only addresses the right to file grievances and appeals without being treated adversely. Policy and Procedure Member Services Functions does not address that this service is the responsibility of Member Services.	Section 3.15 – Rights and Responsibilities of our Members - in the Provider Manual has been updated to capture this requirement.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem The Policy and Procedure Member Services Functions should be updated to include this requirement. Likewise, the Provider Manual should be updated to note the member's freedom to exercise all member rights without adverse treatment. **Final Review Determination** No change in review determination.	
C. Guaranteeing each Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.	New Requirement	Substantial	This is addressed on page 57 of the Member Handbook and pages 33-34 of the Provider Manual. Policy and Procedure Member Services Functions does not address that this service is the responsibility of Member Services. **Recommendation for Anthem** The Policy and Procedure Member Services Functions should be updated to include this requirement. **Final Review Determination** No change in review determination.	The Member Services Functions Policy and Procedure will be updated to include this information.
D. Monitoring the selection and assignment process of PCPs;	Substantial - Policy and Procedure PCP Selection Assignment and Change Requests indicates that these processes are monitored by National Customer Care (NCC).	Full	Policy and Procedure Member Services Functions addresses this requirement. The Member Handbook addresses this on page 6 in the "Your Providers" section.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	The Member Handbook does not address responsibility of Member Services for these functions. Policy and Procedure Member Services Function meets the requirement but the policy was not updated to include the Kentucky requirements until March 2015. **Recommendation for Anthem:** It should be noted in the Member Handbook that these services are provided by Member Services. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. The Member Handbook and the Policy and Procedure did not address this requirement during the review period, CY 2014. Anthem should ensure that the Handbook and Policy are updated as necessary and submitted to DMS.			
E. Identifying, investigating, and resolving Member Grievances about health care services;	Substantial - Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is	Full	Policy and Procedure Member Services Functions addresses the requirement on page 8. The Member Handbook addresses this on	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	responsible for these functions. Policy and Procedure Member Services Function meets the requirement but the policy was not updated to address the Kentucky requirements until March 2015. **Recommendation for Anthem:** It should be noted in the Member Handbook that these services are provided by Member Services. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. The Member Handbook, Provider Manual and the Policy and Procedure did not address this requirement during the review period, CY 2014. Anthem should ensure that the Handbook, Manual, and Policy are updated as necessary and submitted to DMS.		page 46.	
F. Assisting Members with filing formal Appeals regarding plan determinations;	Substantial – See Above.	Full	The Member Handbook addresses this on page 48. Policy and Procedure Member Services Functions addresses this on page 8.	
G. Providing each Member with an identification card	Substantial – See Above.	Full	The Member Handbook addresses this on	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;			page 5. Policy and Procedure Member Services Functions addresses this on page 4.	
H. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this on page 2.	
I. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this on page 2.	
J. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9.	
K. Explaining or answering any questions regarding the Member Handbook;	Substantial - Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is responsible for these functions. Policy and Procedure Member	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this on page 5.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Services Function meets the requirement but the policy was not updated to address the Kentucky requirements until March 2015. **Recommendation for Anthem:** It should be noted in the Member Handbook that these services are provided by Member Services. **MCO Response:** Member Handbook submitted contains required language on page 2. **Final Review Determination:** No change in review determination. The language in the Member Handbook on page 2 is acceptable; however, the Policy and Procedure and Provider Manual did not address the requirements during the review period, CY 2014. Anthem should ensure that the necessary updates to the Policy and Manual are completed and both are submitted to DMS.			
L. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history,	Substantial - Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is responsible for these functions.	Substantial	Policy and Procedure Member Services Functions addresses this on page 9, but does not address the Contractor notifying members within 30 days prior to the effective date of voluntary termination or notifying members within 15 days prior to the effective date of involuntary	The Member Services Functions Policy and Procedure will be updated to include this information.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;	Policy and procedure Member Services Function meets the requirement but the policy was not updated address the Kentucky requirements until March 2015. **Recommendation for Anthem:** It should be noted in the Member Handbook that these services are provided by Member Services. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. The Member Handbook, Provider Manual and the Policy and Procedure did not address this requirement during the review period, CY 2014. Anthem should ensure that the Handbook, Manual, and Policy are updated as necessary and submitted to DMS.		termination of PCPs. The Member Handbook addresses this requirement on page 54. **Recommendation for Anthem** Policy and Procedure Member Services Functions should be updated to include notification of members within 30 days prior to the effective date of voluntary termination and notification of members within 15 days prior to the effective date of involuntary termination of PCPs. **Final Review Determination** No change in review determination.	
M. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this on page 10.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Provider or by the specialty physician being permitted to serve as the Primary Care Provider.				
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this on page 12.	
O. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this requirement within the Covered Services section beginning on page 16.	
P. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases.	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 9. The Member Handbook addresses this requirement.	
Q. Facilitating access to behavioral health services and pharmaceutical services;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 10. This is addressed in the Member Handbook.	
R. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 10. The Member Handbook addresses this on	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and charitable care providers, such as Shriner's Hospital for Children;			page 2.	
S. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 10. The Member Handbook addresses the responsibility of Member Services to assist members with making appointments.	
T. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 10. This requirement is addressed in the Member Handbook on page 14.	
U. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 10. The Member Handbook addresses this requirement on pages 47-49.	
V. Facilitating access to Member Health Education Programs;	Substantial – See Above.	Full	Policy and Procedure Member Services Functions addresses this on page 10. Page 43 of the Member Handbook addresses this requirement.	
W. Assisting members in completing the Health Risk Assessment (HRA) upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and	Substantial – See Above.	Substantial	The Member Handbook addresses this on page 3. Policy and Procedure Member Services Functions does not address this requirement.	The Member Services Functions Policy and Procedure will be updated to include this information.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem Policy and Procedure Member Services Functions should be updated to address this requirement. **Final Review Determination** No change in review determination.	
X. The Member Services staff shall be responsible for making an annual report to management about any changes needed in member services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.	Substantial – See Above.	Full	This requirement is addressed on page 10 of Policy and Procedure Member Services Functions.	
31.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.	Full-2015			
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the	Full-2015			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.				
24.0 Member Selection of Primary Care Provider (PCP)				
24.1 Members Not Required to have a PCP				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP.	Full-2015			
24.2 Member Choice of Primary Care Provider				
Members shall choose or have the Contractor select a PCP for their medical home.	New Requirement	Full	This requirement is addressed on page 6 of the Member Handbook.	
The Contractor shall have two processes in place for Members to choose a PCP: A. A process for Members who have SSI coverage but are not Dual Eligible Members; and B. A process for other Members.	Non-Compliance - Policy and Procedure PCP Selection Assignment and Change Requests does not address the two processes for members to choose a PCP. The MCO noted that Policy and Procedure Member Services Functions will be updated to meet the requirement. The document was revised in March 2015 but the policy provided by the MCO for review, effective in CY 2014, does not contain the required language. **MCO Response:** P&P has been updated with required language.	Full	Policy and Procedure Member Services' Functions, page 9 addresses this requirement.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. The 2 Policies and Procedures did not address this requirement during the review period, CY 2014. Anthem should ensure that the Policies are updated as necessary and submitted to DMS.			
24.6 Primary Care Provider (PCP) Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.	Full-2015			
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.	Full-2015			
A Member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the same Medicaid Region.	Substantial - The Member Handbook, page 8 does not indicate the time limit for members to change PCPs for other than reason. The Provider Manual, 5.4 Automatic Assignment of Primary Care Providers, Procedure for Changing Primary Care Provider or Other Providers, page 44, states that "Members have the right to change	Substantial	The Member Handbook, page 8 indicates that members may change their PCP 90 days after initial assignment and once a year regardless of reason. The Provider Manual does not contain the required language. Section 5.4, page 44, still states "Members have the right to change their PCP at any time." (The 2016 Provider Manual was updated to state that members have the right to change their	Section 5.4 of the Provider Manual has been updated to capture this requirement.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	their PCP at any time." This is not consistent with the Contract requirement. **Recommendation for Anthem:** The member's right to change PCPs within 90 days of the initial assignment and once a year regardless of reason should be added to the Member Handbook. **MCO Response:** Member Handbook has been updated with required language. **Final Review Determination:** No change in review determination. The Member Handbook and Provider Manual do not correctly address the requirements for PCP changes. Anthem should ensure that the Member Handbook and Provider Manual are updated as necessary and submitted to DMS.		PCP at any time for cause) **Recommendation for Anthem** The 2016 Provider Manual should be implemented. **Final Review Determination** No change in review determination.	
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.	Full-2015			

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.	Full-2015			
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.	Substantial - This requirement is not addressed in the Atlas Information Updates-Provider Calls-Terminating Member from a Panel, in the document PCP Changes, or in Policies and Procedures PCP Changes, Primary Care Provider Selection, Assignment and Change Requests – Kentucky and PCP Selection Assignment and Change Requests. The MCO stated that the Provider Manual, Section 2.1 "Responsibilities of the Primary Care Provider" has been updated with language to address the requirement and that the Policy and Procedure Member Services Function will be updated to meet the requirement. **Recommendation for Anthem:** The MCO should add the contract language to the Provider Manual and Policies and Procedures. **MCO Response:** The Provider	Full	This requirement is addressed in section 2.1 of the Provider Manual, Responsibilities of the Primary Care Provider.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Manual and P&P have been updated with required language. **Final Review Determination:** No change in review determination. Anthem should ensure that the Provider Manual, Policies and Procedures, and other documents are updated as needed to address all Kentucky requirements and submitted to DMS. Note that this is addressed in the Member Handbook, on page 8; however the Handbook is dated 01/15.			
The initial PCP must serve until the new PCP begins serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The PCP shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.	Substantial - The Member Handbook addresses changing PCPs and the Provider Manual states members may change providers and the change is made that day in the system. The Provider Manual does not address changes requested by the PCP and neither document states specifically that a member may appeal a transfer to a new PCP or that a member request may be made in writing, face to face, or via telephone. Atlas Information Update, Terminating Member from a Panel; page 2 states that the provider must	Full	This requirement is addressed on page 8, section 2.1, of the Provider Manual under Member Primary Care Physician Change. The Member Handbook also addresses changing PCPs.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	continue to provide care until the effective date for assignment to the new PCP and the provider must send a certified letter to the member and to the MCO. The MCO stated that in 2015, the Provider Manual, Section 2.1 "Responsibilities of the Primary Care Provider" was revised to meet the requirement and that Policy and Procedure Member Services Function and the Member Handbook will be updated to meet the requirement. **Recommendation for Anthem:** The MCO should add the contract language to the Provider Manual and policies and procedures. **MCO Response:** The Provider Manual has been updated with required language. **Final Review Determination:** No change in review determination. Anthem should ensure that the Provider Manual, Member Handbook, Policies and Procedures, and other documents are updated as needed to address all Kentucky requirements and submitted to DMS.			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
31.5 Referrals for Services not Covered by Contractor				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Members for Non-Covered Services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.	Full-2015			

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	30	6	0	0
Total Points	90	12	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Suggested Evidence

Documents

Policies/Procedures for:

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

Member Handbook including any separate inserts or materials
Sample Member newsletters and other informational materials
Sample Provider newsletters and other informational materials
Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics (MCO Report #11)

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Full-2015			
Creative methods should be used to reach Contractor's Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.	Full-2015			
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Full-2015			
23.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.	Full-2015			
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Full-2015			
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of	Full-2015			

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.				
23.5 Member Information Materials				
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,	Full-2015			
be published in at least a 14-point font size, and	Full-2015			
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Non-Compliance - This requirement is not found in Anthem's Policies and Procedures. Anthem referred to the Americans with Disabilities Act Compliance for Participating Providers. The purpose of the policy is "to ensure that providers and vendors are in compliance with ADA requirements. Section Procedures #5 notes that Anthem provides language assistance, interpreters and assistance for the hearing impaired". The policy does not address that written member materials meet the ADA requirement. **MCO Response:** P&P has been updated for 2015. **Final Review Determination:** No change in review determination.	Full	This requirement is addressed in Policy and Procedure Cultural Competency-KY.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Anthem should ensure that the Policy and Procedure is updated to meet the Contract requirements and submitted to DMS.			
Font size requirements shall not apply to Member Identification Cards.	Full-2015			
Braille and audiotapes shall be available for the partially blind and blind.	Full-2015			
Provisions to review written materials for the illiterate shall be available.	Full-2015			
Telecommunication devices for the deaf shall be available.	Full-2015			
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.	Full-2015			
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.	Full-2015			
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.	Full-2015			
In addition. all Member materials concerning behavioral health, with the exception of written materials unique to individual Members, shall be submitted to DBHDID's Director of the Division of Behavioral Health for review prior to publication and distribution to Members.	Not Applicable-2015			
29.14 Cultural Consideration and Competency				

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.	Full-2015			
The Contractor shall communicate such policies to Subcontractors.	Full-2015			

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MCO: Anthem Blue Cross and Blue Shield Medicaid

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Enrollee Rights and Protection: Member Education and Outreach

Suggested Evidence

Documents

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

Reports

Reports of outreach activities

IPRO
Improving Healthcare for the Common Good

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January 2016
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MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
39.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.	Full-2015			
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records**.**	Full-2015			
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Non-Compliance - The MCO did not submit any documentation to address this requirement. **MCO Response:** None **Final Review Determination:** The final review determination is Non-Compliance. Anthem should	Substantial	Policy and Procedure Medical Record Requirements – KY, page 3 addresses this requirement. The Medical Record Documentation Review Form that is completed during onsite provider office visits includes a section related to privacy and security.	Onsite provider visits, for chart audit, and provider education began Q4 2015. Chart audits also conducted Q1 2016. Use of Medical Records Documentation Form for capturing chart details, including compliance with HIPAA and security requirements as well as guidelines for obesity, diabetes, EPSDT visits, depression, and ADHD.

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	develop and implement a Policy and Procedure for conducting HIPAA privacy and security audits of provider sites as prescribed by the Department.		At the onsite review, Anthem reported that HIPAA privacy and security will be reviewed during the onsite provider office monitoring visits scheduled for 2016. **Recommendation for Anthem** Anthem should ensure that the provider office monitoring visits are implemented and that the visits include review for compliance with HIPAA privacy and security requirements. **Final Review Determination** No change in review determination.	Additional chart audits already scheduled for Q22016.
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.	Full-2015			
The Contractor shall have a process to	Minimal - The MCO did not submit any	Minimal	Policy and Procedure Medical Record	Chart audits began in Q4 2015 and continue to be

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.	documentation to address the requirement. During the onsite review, the MCO indicated that medical record compliance reviews will be conducted in conjunction with the HEDIS review. The MCO provided a copy of the following from the Contract: Section 1. Records Maintenance and Audit Rights. Document #17 – With Updates – 2014 Kentucky Health Plan QM Work Plan Final, section Medical Record Review, states the objective as "Maintain a process for ongoing review of provider compliance with evidence-based medical practice, local standards of care and established standards for medical record documentation of care/keeping of medical records, including those required by external regulatory/accrediting agencies and internal established standards." And the measurement / benchmark/goal as "Assess provider compliance with medical record documentation standards. Customize benchmarks/goals as needed. For example: • Mandatory passing on XX critical elements • XX% minimum score • Meet required number of reviews (insert frequency, i.e. quarterly)". The work plan states "records to be reviewed during HEDIS hybrid review." **Recommendation for Anthem:** The MCO should develop a policy and procedure that details the		Requirements – KY addresses this requirement. Anthem did not provide evidence of medical record compliance review results or follow-up actions. At the onsite review, Anthem reported that provider monitoring has not begun but is planned to coincide with HEDIS data collection in 2016. **Recommendation for Anthem** Anthem should conduct medical record compliance reviews in 2016 and implement follow-up actions in response to findings. **Final Review Determination** No change in review determination.	conducted on a quarterly basis based on Policy: Health Plan Quality Management Medical Record Requirements KY (reviewed and submitted to CMAP March 2016). Results of audit reported to providers using Clinical Medical Audit Tool (approved Jan 2014).

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	process for verifying provider compliance with medical record standards. **MCO Response:** A Medical Record Review policy has been developed along with a review template to be utilized during site visits and reviews. This policy is to go through the Policy and Procedure Committee as well as the Quality Committee during Q3. **Final Review Determination:** No change in review determination. The process was not in place and reviews were not conducted in CY 2014. Anthem should ensure that a Policy and Procedure for review of provider compliance with medical record standards and the review template is developed, approved, submitted to DMS and implemented, that improvement actions are taken and effectiveness is evaluated.			
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:	Minimal – See Above.	Minimal	Policy and Procedure Medical Record Requirements – KY addresses this requirement, however, the policy should include the sampling methodology used for each of the provider types listed in the requirement. At the onsite review, Anthem indicated that medical record compliance reviews will be conducted in conjunction with the HEDIS data collection in 2016. **<u>Recommendation for Anthem</u>** Anthem should develop and document in	Policy: Health Plan Quality Management Medical Record Requirements (original date July 2015; revised and submitted to CMAP for approval March 2016).

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			policy, a sampling methodology for selecting providers for medical record compliance reviews. Anthem should conduct medical record compliance reviews in 2016 and implement follow-up actions in response to findings. **Final Review Determination** No change in review determination.	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;	Minimal – See Above.	Minimal	Policy and Procedure Medical Record Requirements – KY addresses this requirement. The Medical Record Documentation Review Form includes monitoring for the following guidelines: obesity and obesity prevention, diabetes, EPSDT visits, major depression and ADHD. At the onsite review, Anthem indicated that medical record compliance reviews will be conducted in conjunction with the HEDIS data collection in 2016. **Recommendation for Anthem** Anthem should conduct medical record compliance reviews in 2016 and implement follow-up actions in response to findings. **Final Review Determination** No change in review determination.	Chart reviews began in Q4 2015; ongoing.
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Minimal – See Above.	Minimal	Policy and Procedure Medical Record Requirements – KY addresses this requirement.	Chart reviews have begun. Ongoing.

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			At the onsite review, Anthem indicated that medical record compliance reviews will be conducted in conjunction with the HEDIS data collection in 2016. **Recommendation for Anthem** Anthem should conduct medical record compliance reviews in 2016 and implement follow-up actions in response to findings. **Final Review Determination** No change in review determination.	
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and	Minimal – See Above.	Minimal	Policy and Procedure Medical Record Requirements – KY states this requirement but does not explain the mechanism or processes used. **Recommendation for Anthem** Anthem should document in a policy and procedure, the mechanism and processes that will be used to identify, investigate and resolve quality of care concerns as part of the medical record compliance reviews. Use of the documented mechanism and processes should be evident in the medical record compliance review results. **Final Review Determination** No change in review determination.	Updated Health Plan Quality Management P&P (Reviewed and Submitted to CMAP for approval March 2016).
D. Include mechanism for detecting instances of over-utilization, under-	Minimal – See Above.	Minimal	Policy and Procedure Medical Record Requirements – KY states this requirement	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
utilization, and miss utilization.			but does not explain the mechanism used. **Recommendation for Anthem** Anthem should document in a policy and procedure, the that will be used for detecting instances of over-utilization, under-utilization and miss-utilization as part of the medical record compliance reviews. Use of the documented mechanism should be evident in the medical record compliance review results. **Final Review Determination** No change in review determination.	Updated Health Plan Quality Management P&P (Reviewed and Submitted to CMAP for approval March 2016). Charts audits conducted in Q4 2015; ongoing.
28.7 Provider Maintenance of Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of	Full-2015			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
services provided under the Contract. The medical record shall be signed by the provider of service.				
The Member's Medical Record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).	Full-2015			
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:	Full-2015			
A. Member/patient identification information, on each page;	Full-2015			
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and	Substantial - Addressed in the Provider Manual, Section 3.13 Record Standards, Member Medical Records page 32. This states that the medical record includes "age, sex, address, employer, home & work telephone numbers and marital status" but does	Full	The 2015 Provider Manual, section 3.13, page 31 addresses this requirement.	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;	not include date of birth, race or ethnicity, school, name & telephone numbers of emergency contacts, consent forms, language spoken and guardianship information. Per the MCO, the Provider Manual was updated in 2015 to include the missing language noted above. **Recommendation for Anthem:** The 2015 Provider Manual should include the required information. The updated Provider Manual will be reviewed during next year's compliance review. **MCO Response:** Provider Manual, section 3.13 was updated to address. **Final Review Determination:** No change in review determination. Anthem should ensure that the requirements are addressed in the updated Provider Manual and that it is submitted to DMS.			
C. Date of data entry and date of encounter;	Full-2015			
D. Provider identification by name;	Full-2015			
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Full-2015			
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e.	Substantial - The Provider Manual, Section 3.13 Record Standards, Member Medical Records, page 32 addressed that documentation must include "serious accidents, operations and serious illness" but does not address "For children, past medical	Full	The 2015 Provider Manual, section 3.13, page 31 addresses this requirement.	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
documentation of chickenpox);	history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox)". Per the MCO, the Provider Manual was updated in 2015; section 3.13 #8, to meet the requirement. **Recommendation for Anthem:** The 2015 Provider Manual should include the required information. The updated Provider Manual will be reviewed during next year's compliance review. **MCO Response:** Provider Manual, section 3.13 was updated to address. **Final Review Determination:** No change in review determination. Anthem should ensure that the requirements are addressed in the updated Provider Manual and that it is submitted to DMS.			
G. Identification of current problems;	Full-2015			
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;	Full-2015			
I. Documentation of immunizations pursuant to 902 KAR 2:060;	Full-2015			
J. Identification and history of nicotine, alcohol use or substance abuse;	Full-2015			
K. Documentation of reportable diseases	Non-Compliance - The requirement is not addressed	Full	The 2015 Provider Manual, section 3.13,	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;	in the Provider Manual. Per the MCO, the Provider Manual was updated in 2015 to meet the requirement. **MCO Response**: Provider Manual, section 3.13 was updated to address. **Final Review Determination:** No change in review determination. The Provider Manual was not compliant during the review period, CY 2014. Anthem should ensure that the updated Manual addresses all requirements.		page 31 addresses this requirement.	
L. Follow-up visits provided secondary to reports of emergency room care;	Full-2015			
M. Hospital discharge summaries;	Full-2015			
N. Advanced Medical Directives, for adults;	Full-2015			
O. All written denials of service and the reason for the denial; and	Non-Compliance - The requirement is not addressed in the Provider Manual. Per the MCO, the Provider Manual was updated in 2015 to meet the requirement. **MCO Response**: Provider Manual, section 3.13 was updated to address. **Final Review Determination:** No change in review determination. The Provider Manual was not compliant during the review period, CY 2014. Anthem should ensure that the updated Manual	Full	The 2015 Provider Manual, section 3.13, page 31 addresses this requirement.	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	addresses all requirements.			
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.	Full-2015			
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;	Full-2015			
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and	Full-2015			
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.	Non-Compliance - The requirement is not addressed in the Provider Manual. Per the MCO, the Provider Manual was updated in 2015 to meet the requirement. **MCO Response**: Provider Manual, section 3.14 was updated to address. **Final Review Determination:** No change in review determination. The Provider Manual was not	Full	The 2015 Provider Manual, section 3.13, page 31; and section 3.14, page 33 address this requirement.	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	compliant during the review period, CY 2014. Anthem should ensure that the updated Manual addresses all requirements.			
28.8 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.	Full-2015			
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.	Full-2015			
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in	Full-2015			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the medical record of the Member.				
39.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 41.15.	Full-2015			
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.	Minimal - Addressed in the Provider Manual, Maintain Medical Records, states "Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients. Comply with all applicable federal and state laws regarding the confidentiality of patient records." The Provider Manual, Section 3.10 Health Insurance Portability and Accountability Act, pages 29-30, addresses general HIPAA/confidentiality requirements. A specific policy/procedure that includes the language "adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without	Substantial	The Provider Manual, section 3.10 Health Insurance Portability and Accountability Act, page 29 addresses provisions for assuring confidentiality of services for minors. The Provider Manual does not address how to contact the minor member for any needed follow-up and limitations on telephone or mail contact to the home. Section 2.10 of the Provider Manual addresses diagnosis and treatment of minors without parental notification or consent but does not address how to contact the minor member. In addition, the provider agreement does not address this requirement. **Recommendation for Anthem**	Provider Manual updated Health Plan Quality Management Medical Records Requirement KY (revised and submitted to CMAP for approval in March 2016)

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	parental notification or consent as specified in KRS 214.185." or addresses "issues such as how to contact the minor member for any needed follow-up and limitations on telephone or mail contact to the home" was not found. Per the MCO, the Provider Manual Section 3.10 was updated in 2015 to address this requirement. **Recommendation for Anthem:** The 2015 Provider Manual should include the required information. The updated Provider Manual will be reviewed during next year's compliance review. **MCO Response:** Provider Manual, section 3.10 was updated to address. **Final Review Determination:** No change in review determination. The Provider Manual was not compliant during the review period, CY 2014. Anthem should ensure that the updated Manual addresses all requirements.		The Provider Manual should be updated to include information on how to contact a minor member for any needed follow-up as well as limitations on telephone or mail contact to the home. **Final Review Determination** No change in review determination.	
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Full-2015			
Except as otherwise required by law, regulations or this Contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of	Full-2015			

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.				
41.15 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as are the Contractor.	Full-2015			

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	2	6	0
Total Points	15	4	6	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average			1.92	

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

Reviewer Decision:

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

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

Final Findings

Medical Records

Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Provider compliance assessment/monitoring results and follow-up

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.2 Requirements for Behavioral Health Services				
The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Members with SMI and SED, including Members with co-occurring developmental disabilities, substance use disorders and smoking cessation. The Contractor in its design and operation of behavioral health services shall incorporate these core values for Medicaid Members: A. Members have the right to retain the fullest control possible over their behavior health treatment. Behavioral health services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare. B. The Contractor shall provide the most normative care in the least restrictive setting and serve Members in the community to the greatest extent possible. C. The Contractor shall measure Members' satisfaction with the services they receive. D. The Contractor's behavioral health services shall be recovery and resiliency focused.	Substantial - The Provider Manual addresses all aspects of this requirement in detail. The Member Handbook pages 42, 53 and 57 address member decision making about their care. Policy and Procedure, Member Rights and Responsibilities – Kentucky addresses consent, refusal and active participation in decisions. The QM Program Description includes behavioral health services as integrated into the overall quality management program, and a member centric approach to physical and behavioral health is described in reference to disease management. Access to Behavioral Health Care does not address the recovery and resiliency focused provision of behavioral health services. Anthem does not have a specific Policy and Procedure or Program Description that addresses behavioral health services. Onsite staff indicated that this is pending. **Recommendation for Anthem:** The MCO should include the provision of recovery and resiliency focused behavioral health services in existing policy/procedure or specific behavioral health	Substantial	Anthem did not submit a policy/procedure or program description addressing the recovery and resiliency focused provision of behavioral health services. The Provider Manual does address this requirement. The Quality Management Program Description does address behavioral health services, but it does not address recovery and resiliency-focused services. **Recommendation for Anthem** As noted in last review, Anthem should include the provision of recovery and resiliency focused behavioral health services in existing policy/procedure or in a Kentucky-specific behavioral health program description or general policy. **Final Review Determination** No change in review determination.	On 3/14/2016, P&P: *Delivery of Behavioral Health Services* was updated to include recovery and resiliency. P&P: *Delivery of Behavioral Health Services* will be submitted to the Policy and Procedure Oversight Committee in April for review and approval. Delivery of Behavioral Health Ser

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	program description or general policy. **MCO Response:** Anthem will include the provision of recovery and resiliency focused behavioral health services in existing policy/procedure or specific behavioral health program description or general policy. Plan – Policy recommendations will be escalated through Care Management Services Governance committee for review and approval through policy and procedure committee for completion by July 2015. **Final Review Determination:** No change in review determination. Anthem should ensure that a Policy and Procedure or Program Description is developed for behavioral health services and that it addresses all requirements and is submitted to DMS.			
34.3 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix H.	Full-2015			
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and	Full-2015			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
assessment instrument/outcome measures in addition to the most current version of DSM.				
Providers shall document DSM diagnosis and assessment/outcome information in the Member's medical record.	Full-2015			
34.4 Behavioral Health Provider Network				
The Contractor shall provide access to Psychiatrists, Psychologists, and other behavioral health service providers.	Full-2015			
Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of behavioral health services include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations, Licensed Clinical Social Workers, Certified Family, Youth and Peer Support Providers, Targeted Case Managers and other independently licensed behavioral health professions.	Full-2015			
To the extent that non-psychiatrists and other providers of Behavioral Health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Substantial - The Kentucky Medicaid BH Service Grid includes FQHCs and RHCs as providers (place of service) for Behavioral Health services. The provision of behavioral health services by FQHCs and RHCs is not specifically addressed in policies or procedures.	Substantial	Anthem did not provide a policy/procedure that addresses provision of behavioral health services by FQHCs or RHCs. The updated Provider Manual submitted by the MCO does not appear to specifically address the continued provision of behavioral	On 3/14/2016, P&P: ***Access to Behavioral Health Care*** was submitted. Reviewed and approved by the Policy and Procedure Oversight Committee on 3/17/2016, and includes language pertaining to the provision of behavioral health services by FQHCs and RHCs.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for Anthem: The MCO should address the provision of behavioral health services by FQHCs and RHCs in policy/procedure. **MCO Response:** Anthem will address the provision of behavioral health services by FQHCs and RHCs in policy/procedure. Plan – policy will be updated to include specifically FQHC, Rural Health Clinics, and other allowed behavioral health professionals and organizations for approval through policy and procedure committee and to be finalized in July 2015. **Final Review Determination:** No change in review determination. Anthem should ensure that the Policy addresses all requirements, is approved, and is submitted to DMS.		health services currently provided under their license by FQHCs and RHCs. **Recommendation for Anthem** Anthem should include the provision of behavioral health services by FQHCs and RHCs in policy/procedure and/or Provider Manual. **Final Review Determination** No change in review determination.	Access to Behavioral Health Care.docx
34.5 Member Access to Behavioral Health Services				
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Full-2015			
In order to ensure such accessibility, the Contractor shall submit credentialing documents for no fewer than five hundred (500) independent behavioral health individual providers distributed throughout the state, not including providers linked or affiliated with the following licensed organizations: a CMHC, a BHSO, a FQHC, or a RHC, on or by January 1, 2016.	New Requirement	Full	Anthem indicated that documentation would be provided at onsite review. While onsite, staff provided documentation that addresses this requirement. Correspondence with DMS regarding this requirement and an Excel sheet of applicable providers was	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			presented onsite. The Excel spreadsheet document is titled BH Provider Report 12.31.15 DMS. This document includes codes for provider type to differentiate these providers from CMHCs, BHSOs, FQHCs and RHCs, and there are 730 applicable providers listed.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services. The Member Manual shall contain information for Members on how to direct their behavioral health care, as appropriate.	Substantial - Access to behavioral health services is addressed in the Member Handbook, which provides a crisis hotline number for members if they need mental health or substance abuse services or feel they are in crisis. The Behavioral Health Telephonic Intake Protocol for Members outlines procedures for assisting members who call the MCO for access to routine and urgent behavioral health care services. Although members can access behavioral health services directly according to the 2014 Kentucky UM Program Description, this is not referenced in the Member Handbook. The Member Handbook, page 6, indicates that the member's PCP will refer to other providers if the member needs behavioral health services. **Recommendation for Anthem:** The MCO should inform members regarding direct access to behavioral health services in the Member	Full	This requirement is addressed in Member Handbook, pages 4, 13 and 31.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Handbook and educate members regarding direct access to behavioral health services. **MCO Response:** Anthem will inform members regarding direct access to behavioral health services in the Member Handbook and educate members regarding direct access to behavioral health services. Plan – revision to member handbook for distribution to members and member services to also educate members upon initial calls requesting services. **Final Review Determination:** No change in review determination. Anthem should ensure that the Member Handbook contains the required information and that a process to educate members regarding access to BH services is developed and implemented.			
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.	Full-2015			
34.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free	Minimal - This requirement is addressed in the 2014 Kentucky UM Program Description, which indicates that the MCO provides this hotline and that calls to request behavioral health services	Non-Compliance	Anthem provided several documents that reference the behavioral health services hotline pre-onsite.	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
throughout the Commonwealth.	are screened by a behavioral health care services technician. The UM Program Description refers to the Behavioral Health Telephonic Intake Protocol for the centralized Behavioral Health Call Center. The Behavioral Health Telephonic Intake Protocol For Members addresses the process for UM to answer BH calls during normal business hours and for the BH After Hours Call Center staff to provide intake services for BH member calls after hours. Members with urgent needs calling during business hours are transferred to the "crisis call queue" to a Case Management Clinician. Emergency calls are forwarded to "appropriate plan case management unit for follow-up per market procedures". There is no reference to Kentucky-specific procedures. After-hours calls are received by "Behavioral Health After Hours Call Center Staff", who notify BH UM via email the next business day and notices are immediately forwarded to the appropriate health MCO case management lead for follow up. The Member Handbook provides a crisis hotline number for members if they need mental health or substance abuse services or feel they are in crisis. The phone number for the crisis hotline in the Member Handbook is the same as the		The Member Handbook provides members with the 24-hour crisis hotline number if they need mental health or substance abuse services or feel they are in crisis. The phone number for the crisis hotline in the Member Handbook is the same as the Behavioral Health Crisis Line number listed in the Provider Manual. The number listed in the Member Handbook for Behavioral Health Services on pages 4 and 31, and cited as the number to call if you feel you are in crisis and as the Behavioral Health Services 24 hour Crisis Hotline, is the same number as that listed for long term care and maternity services. Four policies/procedures were provided and discussed onsite. These policies and procedures were not consistent regarding the process for behavioral health crisis calls and staff responsible for the calls. Onsite interviews with MCO and corporate staff did not clarify the process and staffing for behavioral health crisis line calls. The pre-onsite documentation included the following documents. The Policies and Procedures Behavioral Health Telephonic Intake Protocol for Members and Behavioral Health Crisis	staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Behavioral Health Crisis Line number listed in the Provider Manual, which indicates that this number has live agents available Monday through Friday 7am to 7pm. Onsite staff provided a protocol for warm transfers of any member calling the MCO with urgent behavioral health needs to the Behavioral Health Team, entitled Anthem Operating Guidelines, "Warm Transfers" into Behavioral Health Services. Callers are transferred to the centralized Behavioral Health Call Center, which as per onsite staff is staffed by licensed clinicians. For urgent needs, the call is warm transferred to a Behavioral Health Care Manager. This protocol was updated on 1/1/2015. **Recommendation for Anthem:** Anthem should ensure consistency of documents regarding twenty four hour staffing of the Behavioral Health hotline and include Kentucky-specific procedures for urgent calls referred to the MCO from the Behavioral Health Call Center in policy/procedure. In order to ensure that requirements are met, the MCO should consider developing a Kentucky-specific Behavioral Health Services hotline Policy and Procedure. **MCO Response:** Anthem will ensure consistency		Call Procedure include or reference state-specific requirements. Neither document includes Kentucky-specific requirements. Behavioral Health Crisis Call Procedure was submitted but is not dated and it was not clear to whom this procedure applied. This policy states that crisis calls received during business hours are forwarded to the Behavioral Health Call Center. BH Department hours are 8am-9pm EST, M-F. Calls (including crisis calls) received after-hours or on weekends are handled by the St. Louis after-hours call center. This procedure notes that certain states have specific crisis protocols in place. BH department staff will direct callers as appropriate. Kentucky-specific crisis protocols were not noted in the documents provided. Onsite staff indicated that this was an internal document and should not have been submitted for pre-onsite documentation for this review. Policy and Procedure Behavioral Health Telephonic Intake Protocol for Members This policy/procedure addresses calls requesting behavioral health services	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	of documents regarding twenty four hour staffing of the Behavioral Health hotline and include Kentucky-specific procedures for urgent calls referred to the MCO from the Behavioral Health Call Center in policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.		received during business hours and after-hours and is for use by the Behavioral Health Department. Onsite staff clarified that the Behavioral Health Department is located centrally. Calls requesting referral for behavioral health care received during business hours are screened by a Utilization Management Representative (UMR) to determine severity. If the request is routine, the UMR provides the member with at least 3 referrals to appropriate behavioral health professionals. For members with more immediate needs, the UMR transfers the call to a crisis call queue for immediate assistance, without placing the member on hold. The Care Manager (CM), a clinician, assesses the member's clinical condition to determine an acuity level. If the member meets the criteria for emergency-life-threatening, the CM arranges for an immediate face-to-face evaluation. If necessary, the CM obtains assistance from other clinical staff in contacting emergency personnel, while remaining engaged with the member on the telephone. If the member needs urgent care, the CM assists the member in arranging an appointment for evaluation within 48 hours.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Calls received after Behavioral Health business hours are handled by the BH After Hours Call Center staff. Onsite staff provided an additional Policy and Procedure Behavioral Health Staffing that indicates that Behavioral Health Care Managers, who are licensed Behavioral Health Providers, are onsite at the BH After Hours Call Center during non-business hours. The after-hours staff assists members to obtain immediate assistance in emergencies, and may contact emergency services if necessary. When urgent/emergent calls are received after-hours, the staff documents the member's demographic information, circumstances of the call and disposition. This information is transmitted electronically to the BH UM the next business day. These notices are immediately forwarded to the appropriate MCO case management lead for follow-up by appropriate staff at the local level. As per Policy and Procedure Behavioral Health Telephonic Intake Protocol for Members, non-emergent after-hours calls are advised via recorded message	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			to contact the BH department on the next business day. It appears from this document and discussions with onsite staff that members self-triage on an Interactive Voice Response (IVR) system to emergency or non-emergency categories. As noted above, included in this policy are some state-specific requirements but none for Kentucky. Policy Number G 4.010, Crisis Calls Requiring Emergency Intervention indicates that the BH Resource Center customer care representatives (CCR) determine if a call is urgent or emergent through use of a silent assessment checklist. Clinical associates rank the cases according to acuity. Crisis calls are managed by licensed behavioral clinicians. In contrast to Policy and Procedure Behavioral Health Telephonic Intake Protocol for Members discussed above, this policy refers to CCRs, not UMRs, and refers to clinical associates rather than care managers. During several discussions with onsite staff, there were varying explanations of the position description and roles of these titles. It	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			appeared ultimately that UMRs were non-clinical staff and Behavioral Health Case Managers are clinical staff. The policy further states that program members identified as experiencing an acute, potentially life-threatening crisis are triaged immediately to their local emergency medical services (i.e. 911 services). Non clinical associates and Health Professionals should attempt to warm transfer calls to a program Nurse Care Manager (NCM) during business hours (does not apply to Integrated Health Model (IHM)) or to a NurseLine (NL) NCM after business hours. Behavioral Health will follow their procedures related to warm transfer. The role and BH background of the NurseLine NCM in the behavioral health hotline process is not clear. In contrast to Policy and Procedure Behavioral Health Telephonic Intake Protocol for Members discussed above, this policy refers to referral to a NCM during business hours vs. a care manager in the BH Telephonic Intake Protocol. This policy also refers to after-hours referral to a NurseLine NCM whereas the BH Telephonic Intake Protocol refers to the BH after-hours call	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			center staff. Again, it is not clear who is responsible for handling the calls. Page 6 of this policy refers to sending of BH referral forms to Medicare BH. It is not clear if this policy applies to Medicaid. Policy Number GBD-CM-015, Handling Suspected Emergencies During Telephonic Contact with Members provides guidelines for case management associates to manage situations during telephonic contact with members in which the associate suspects an emergency situation to be present (medical and/or psychiatric in nature). Unlike the other policies discussed above, this policy refers to case management associates, a title not used in the other documents provided. While onsite, the behavioral health crisis line procedure was discussed with MCO staff and corporate staff, including staff from the Behavioral Health National Call Center. The procedure described included the member contacting an IVR system and selecting 9 for accessing the crisis line if they felt they were in danger	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			of hurting themselves or others. There was some inconsistency among staff on this conference call regarding the routing of calls; whether customer service was involved in the process; staff titles, roles and clinical background. During a subsequent conference call with onsite MCO staff and the Director of Program Operations, the process was again described as the member accessing an IVR system with early opportunity to access a crisis line if the member is experiencing a behavioral health crisis. During this call, it was indicated that the member accessing the crisis line selection was first queried by a UMR, who is not a clinical staff member, to determine the nature of the crisis. If determined to be a routine call, the UMR would handle it as a routine call. If it was determined to be a crisis call, the caller would be warm transferred to a clinician. The information regarding crisis calls is relayed to the MCO Care Management, who then follow-up with the member. Documented examples of follow-up of crisis calls referred to Care Management were requested onsite, but these were not available for review. It was indicated on this call that Customer	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Services would only be involved if the call was referred to them by the National Call Center for issues such as how to get a claim paid. Onsite staff provided an internal algorithm of crisis call routing that was not dated or labeled. This document was not consistent with other documents. Processes and staff responsible for behavioral health crisis calls and a 24/7 staffed behavioral health hotline were not clear following onsite interviews. A call to the Behavioral Health Crisis Hotline number in the Member Handbook resulted in access to an IVR system that appeared to be a general customer services line. The initial instruction is to call 911 if the call is regarding a medical emergency. The next query is regarding whether the caller is a member or provider. If member selected, the IVR system asks for entry of Member ID, and inquires a second time for Member ID. If Member ID is not available, the member is asked to stay on the line and someone will assist. To this point there was no prompt for accessing a behavioral health crisis line. It should be noted that	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			the number given to members for the Behavioral Health Crisis Hotline is the same number given to members for Member Services and Nurse Advice Line. **Recommendation for Anthem** Anthem should ensure that there is a clear Policy and Procedure available to and understood by all involved staff that details the process for Kentucky members to access an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year. There should be a consistent policy and procedure for all involved staff so that calls are consistently handled, and roles and responsibilities, as well as job titles, should be clearly defined. The MCO should ensure that a member in crisis who is calling a number described as a behavioral health crisis hotline should have immediate access to a behavioral health crisis hotline. Kentucky-specific requirements should be included in policies and procedures. **Final Review Determination** No change in review determination.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Substantial - The 2014 Kentucky UM Program Description indicates that trained personnel staff the behavioral health services hotline. As noted above, qualifications of hotline staff are not specified in Policy and Procedure, although onsite staff indicated that the Behavioral Health Call Center is staffed by clinicians during the day. **Recommendation for Anthem:** The MCO should specify qualifications of behavioral health services professionals staffing the crisis hotline or who are accessible to crisis hotline staff to provide assessment, triage and intervention for behavioral health emergencies. **MCO Response:** Anthem will specify qualifications of behavioral health services professionals staffing the crisis hotline or who are accessible to crisis hotline staff to provide assessment, triage and intervention for behavioral health emergencies. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.	Minimal	Anthem provided the Crisis Calls Requiring Emergency Intervention policy. Page 2 of this document states that for the Behavioral Health Resource Center, customer care representatives determine if a call is urgent or emergent through use of the Silent Assessment checklist and immediately refer these cases to the Behavioral Health Care Manager. Clinical associates rank the cases according to acuity as urgent or emergent in order to contain risk and to assure that clients are seen within the guidelines by a mental health provider. Crisis calls are managed by licensed behavioral clinicians who are skilled in calmly completing an assessment and promoting caller safety by arranging necessary interventions. The policy, page 6, addresses referrals by non-clinical associates to behavioral health clinical care managers when a member is exhibiting emotional and/or physical distress. The policies submitted refer to staff in various ways, such as customer care representatives, clinical care managers, Utilization Management representatives and clinical associates. None of the pre-onsite policies specifically address the	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			qualifications of the call center staff. The Policy and Procedure Behavioral Health Staffing that includes the availability of clinical behavioral health Care Managers at call centers, but this document does not specifically address a crisis hotline and references the NurseLine. It is unclear if or how the NurseLine interfaces with the behavioral health crisis hotline. **Recommendation for Anthem** Anthem should specify qualifications of behavioral health services professionals staffing the crisis hotline and those who are accessible to crisis hotline staff to provide assessment, triage and intervention for behavioral health emergencies. Hotline staffing should be clear and consistent across policies and procedures regarding roles, responsibilities and clinical background. Kentucky-specific requirements should be included in policies and procedures. **Final Review Determination** No change in review determination.	
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Minimal - This requirement is addressed in the Behavioral Health Telephonic Intake Protocol. The Behavioral Health Telephonic Intake Protocol addresses arranging for immediate	Minimal	The Behavioral Health Telephonic Intake Protocol addresses arranging for immediate face-to-face evaluation for calls received during business hours.	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	face-to-face evaluation for calls received during business hours. Accessing mobile crisis teams and procedure for arranging face-to-face emergency services are not specifically addressed in this protocol. Accessing local emergency services (911) is addressed in Anthem Operating Guidelines, "Warm Transfers" into Behavioral Health Services. **Recommendation for Anthem:** The MCO should include accessing mobile crisis teams in policy and procedure and include procedures for arranging for face-to-face evaluation after hours in protocol. **MCO Response:** Anthem will include accessing mobile crisis teams in policy and procedure and include procedures for arranging for face-to-face evaluation after hours in protocol. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.		Accessing mobile crisis teams and procedure for arranging face-to-face emergency services are not specifically addressed in this protocol. Policy Number G 4.010, Crisis Calls Requiring Emergency Intervention, page 4 states: "Connecting a Member to EMS 6. If a responsible adult is at the member's location, the NCM obtains the member's name and telephone number and instructs the responsible adult to hang up and dial 911 or "0" for the operator to obtain their local emergency services. 6.1. The NCM returns a call to the caller within 15 minutes of the first call to verify that 911 has been called. 6.2. If activating EMS, follow the steps below. 7. If there is no responsible adult with the member, the NCM assists the member to access emergency services. 7.1. The NCM obtains the member's name, telephone number with area code, and complete physical address, if possible. 7.2. The NCM locates the correct local number for emergency medical services by using either: 7.2.1. The 911 Directory: http://stdc1chshrsapp1/911/	staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			7.2.2. The 911 Tab in Genesys® Agent Desktop (GAD) 7.2.3. Calling Directory Assistance (1+ area code + 555-1212) and requesting the number of EMS for the relevant county or city. 7.3. The NCM informs the member that he/she is being transferred to 911. 7.4. The NCM transfers the member to the appropriate number. 7.5. The NCM stays on the line to introduce the member, provide history and verify a successful call transfer. 8. After the member has been successfully transferred, the NCM completes the call, schedules a follow-up call (as appropriate) and documents the call content. 9. Document this referral to Emergency Services in the Referral Center, with referral type of Emergency Services and referral reason as EMS." None of the policies submitted address face-to-face evaluation after hours. Mobile crisis teams are not addressed in documents provided.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem The MCO should include processes for accessing mobile crisis teams and after-hours face-to-face evaluation for Kentucky members in Policy and Procedure. **Final Review Determination** No change in review determination.	
It is not acceptable for an intake line to be answered by an answering machine.	Substantial - This requirement is addressed in the 2014 Kentucky UM Program Description and the Behavioral Health Telephonic Intake Protocol for Members. The UM Program Description indicates that the hotline is staffed twenty four hours a day, seven days a week. The Behavioral Health Telephonic Intake Protocol for Members refers to a recorded message for when BH after hours clinical staff "receives non-emergent" calls, although the rest of the document refers to staff answering calls. As noted above, the Provider Manual indicates that the number identified as the Behavioral Health Crisis Line has live agents available Monday through Friday 7am to 7pm. **Recommendation for Anthem:** The MCO should ensure that all policies, procedures and manuals consistently reflect the requirement that intake lines are not answered by answering machines.	Non-compliance	The Policy and Procedure Behavioral Health Telephonic Intake Protocol for Members refers to a recorded message when behavioral health after-hours staff receives non-emergent after behavioral health business hours calls. Callers are advised via a recorded message to contact the behavioral health department on the next business day. It appears that when members contact the Behavioral Health crisis hotline number identified in the Member Handbook, an IVR system prompts the member to self-triage to a crisis line if the member believes they are in danger of hurting themselves or other. If the member does not select this option, it is not clear that the caller will always access a live person rather than a recorded message. As noted above, there are several steps in the IVR system	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Anthem will ensure that all policies, procedures and manuals consistently reflect the requirement that intake lines are not answered by answering machines. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.		prior to a member reaching an option to choose a crisis line. Per the Behavioral Health Crisis Call Procedure, calls received during business hours are forwarded to the Behavioral Health Call Center. Calls received after-hours or on weekends are handled by the St. Louis after-hours call center. None of the policies refer to use or non-use of an answering machine. **Recommendation for Anthem** Anthem should ensure and specify in policy and procedure that Kentucky members accessing the behavioral health crisis hotline number will not be routed to an answering machine. **Final Review Determination** No change in review determination.	
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs:	Substantial - See subcomponents below.	Minimal	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) **Final Review Determination** No change in review determination.	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs." The CAP was approved by the

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Department on March 14, 2016.
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;	Substantial - MCO Report #11 Call Center indicates that 100% of calls were answered by the fourth (4th) ring. This requirement is not specified in Telephonic Access Guidelines. **Recommendation for Anthem:** The MCO should include this requirement for behavioral health hotline calls in policy/procedure. **MCO Response:** Anthem will include this requirement for behavioral health hotline calls in policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.	Minimal	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) A policy/procedure addressing this requirement was not provided. Anthem met this requirement for calls received during Q1-Q3 2015. Q4 reports were not available at the time of this review. It should be noted that hotline calls are not differentiated from other behavioral health calls in quarterly reports, although 100% of behavioral health calls were answered on or before the fourth ring. As per onsite interviews, it is not clear how Behavioral Health hotline calls are identified and tracked, i.e. what the start point for the timeframe of a hotline call begins. A call by reviewers to the number provided to members as the hotline number was answered after the fourth ring and not immediately answered by the Behavioral Health Department. **Recommendation for Anthem**	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Anthem should ensure that Kentucky-specific requirements for Behavioral Health hotline calls are included in policy and procedure, and that there is an established hotline number for which calls can be identified and tracked to ensure call answering criteria are consistently met. **Final Review Determination** No change in review determination.	
B. No incoming calls receive a busy signal;	Substantial - This requirement is addressed in MCO Report #11 Call Center, with 0% of incoming calls receiving a busy signal. This requirement is not specified in Telephonic Access Guidelines. **Recommendation for Anthem:** The MCO should include this requirement for behavioral health hotline calls in policy/procedure. **MCO Response:** Anthem will include this requirement for behavioral health hotline calls in policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.	Minimal	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) A policy/procedure addressing this requirement was not provided. Anthem met this requirement for calls received during Q1-Q3 2015. Q4 reports were not available at the time of this review. Although hotline calls are not differentiated from other behavioral health calls, 0% of callers received a busy signal. **Recommendation for Anthem** Anthem should ensure that Kentucky-specific requirements for Behavioral Health hotline calls are included in policy and procedure, and that there is	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			an established hotline number for which calls can be identified and tracked to ensure call answering criteria are consistently met. **Final Review Determination** No change in review determination.	
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;	Substantial - This requirement is addressed in MCO Report #11 Call Center, with at least 80% of calls answered within 30 seconds. This standard is included in Telephonic Access Guidelines as an internal benchmark of "average speed to answer <30 seconds." **Recommendation for Anthem:** The MCO should include this requirement for behavioral health hotline calls in policy/procedure. **MCO Response:** Anthem will include this requirement for behavioral health hotline calls in policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.	Minimal	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) A policy/procedure addressing this requirement was not provided. Anthem met this requirement for calls received during Q1-Q3 2015. Q4 reports were not available at the time of this review. Although 80% of after-hours Behavioral Health calls in Q3 were answered within 30 seconds, Behavioral Health hotline calls are not differentiated. The specific rate for hotline calls could therefore not be ascertained. **Recommendation for Anthem** Anthem should ensure that Kentucky-specific requirements for Behavioral Health hotline calls are included in policy and procedure, and that there is an established hotline number for which	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			calls can be identified and tracked to ensure call answering criteria are consistently met. **Final Review Determination** No change in review determination.	
D. The call abandonment rate is seven percent (7%) or less;	Full-2015		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
E. The average hold time is two (2) minutes or less; and	Non-Compliance - This requirement is not addressed in MCO Report #11 Call Center. This requirement for hotline calls is not specified in policy/procedure. **Recommendation for Anthem:** The MCO should monitor this statistic for hotline calls. The MCO should include specific requirements for behavioral health hotline calls in policy/procedure. **MCO Response:** Anthem will monitor the average hold time statistic for hotline calls and include specific requirements for behavioral health hotline calls in policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed and that all required metrics are	Minimal	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) A policy/procedure addressing this requirement was not provided. Average Speed to Answer ranged from 3-12 seconds per month for Q1-Q3. Q4 reports were not available at the time of this review. Behavioral Health hotline calls are not differentiated. **Recommendation for Anthem** Anthem should ensure that Kentucky-specific requirements for Behavioral Health hotline calls are included in policy and procedure, and that there is an established hotline number for which calls can be identified and tracked to ensure call answering criteria are	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	reported.		consistently met. **Final Review Determination** No change in review determination.	
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.	Minimal - Accessing emergency services is addressed in the Behavioral Health Telephonic Intake Protocol for Members and Anthem Operating Guidelines, "Warm Transfers" into Behavioral Health Services. Procedures for accessing emergency services after hours are not clear in the Behavioral Health Telephonic Intake Protocol for Members. Accessing emergency services is addressed in Anthem Operating Guidelines, "Warm Transfers" into Behavioral Health Services for Behavioral Health Care Management staff fielding emergency calls, who can "instant message a coworker, who will call the local emergency services number". Behavioral Health Telephonic Intake Protocol for Members indicates that behavioral health after-hours staff may contact emergency services if necessary, otherwise notices of urgent/emergent calls are forwarded to appropriate MCO case management staff for follow-up by appropriate staff. Procedures at the Kentucky Medicaid Plan level are not specified. Immediate connection to Suicide Hotline	Minimal	Policy and Procedure Behavioral Health Telephonic Intake Protocol for Members refers to referrals to the crisis call queue for immediate assistance and also refers to a care manager determining an acuity level and contacting emergency personnel (pages 2-3). The policy G 4.010 Crisis Calls Requiring Emergency Intervention provides a list, not all-inclusive, of true medical emergencies that are appropriate for transfer to 911. Auditory or visual hallucinations suggestive of suicidal or homicidal commands/ideations are included. The policy further states that for members communicating information regarding life-threatening suicidal gestures, the nurse case manager uses professional judgment and experience to determine if completion of the suicide triage assessment is appropriate based on the member's condition. Under the section, Suicide Member Triage, the nurse case manager	A CAP was submitted on March 7, 2016, to address the gap related to "The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth." The CAP was approved by the Department on March 14, 2016.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	telephone number, other Crisis Response Systems and patch capabilities to 911 emergency services are not specifically addressed in policy/procedure. **Recommendation for Anthem:** The MCO should ensure for immediate connection to local Suicide Hotline and other Crisis Response teams are clear in policy/procedure, including for behavioral health after hours staff. **MCO Response:** Anthem will implement the recommendation to ensure immediate connection to local Suicide Hotline and other Crisis Response teams are clear in policy/procedure, including for behavioral health after hours staff. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.		completes the suicide triage assessment, determines what resources the member has available (i.e., EAP; Mental Health) and warm transfers the call to the appropriate 911 number as needed depending on the severity of the condition/issue or have a competent adult activate EMS; or warm transfers the member to an EAP clinician if the member has Anthem EAP. Although accessing 911 and emergency services is addressed in policy procedure, accessing a Suicide hotline and other Crisis Response teams is not mentioned in any policy. **Recommendation for Anthem** The MCO should ensure that mechanisms for immediate connection to local Suicide Hotline and other Crisis Response teams for Kentucky members are clear in policy/procedure, including for behavioral health after hours staff. **Final Review Determination** No change in review determination.	
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.	Full-2015			
The Contractor cannot impose maximum call duration	Substantial - MCO Report #11 Call Center	Full	Policies and procedures do not impose	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.	provides average length of behavioral health calls in minutes that range from 5 minutes to 24 minutes for after hours calls. Policies and procedures do not impose maximum call duration limits, and the Telephonic Intake Protocol for Members includes provision for keeping members engaged on the telephone and staying on the line with members in urgent situations. **Recommendation for Anthem:** The MCO should include this requirement in policy/procedure. **MCO Response:** Anthem will include this requirement in policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.		maximum call duration limits, and the Telephonic Intake Protocol for Members includes provision for keeping members engaged on the telephone and staying on the line with members in urgent situations. The policy purpose is to ensure that members requesting assistance in accessing behavioral health care receive adequate screening and referral to assist them in accessing care based on the acuity level and individual needs of the member.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Minimal - Corporate Policy Cultural Competency addresses cultural competency responsibilities and training in general for MCO associates. Interpreter services in general are addressed in Access and Availability-Kentucky. Cultural competency and linguistic access are not addressed specifically with regard to hotline services.	Full	Addressed in Policy and Procedure Oral Translation/Interpretation Services, Policy G4-020 Managing Members Who Do Not Speak English and Policy G4-095 Special Communications Needs.	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Recommendation for Anthem: The MCO should include cultural competency and interpretation services in behavioral health hotline policy/procedure. **MCO Response:** Anthem will include cultural competency and interpretation services in behavioral health hotline policy/procedure. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH Hotline services are fully and consistently addressed.			
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs.	Full-2015			
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Full-2015			
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Full-2015		Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results)	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department and DBHDID for approval. The Contractor will work directly with DBHDID to introduce the evidence based tool Screening, Brief Intervention, Referral, and Treatment (SBRIT) in appropriate PCP settings.	Substantial - This requirement is addressed in the Provider Manual and the provider contract document Medicaid Participation Addendum to the Blue Cross Blue Shield Medicaid Provider Agreement. Screening tools are available on the MCO's provider website. The MCO has not yet addressed introducing the SBIRT in appropriate PCP settings, and it is notable that the number of PCPs conducting substance abuse screening reported in MCO Report #118 Behavioral Health Outcomes is very low. **Recommendation for Anthem:** The MCO should proceed with working with DBHDID to introduce the SBIRT in PCP settings to facilitate substance abuse screening by PCPs. **MCO Response:** Anthem will proceed with working with DBHDID to introduce the SBIRT in PCP settings to facilitate substance abuse screening by PCPs. Plan – Anthem will continue to work with DBHDID on monthly basis to develop a work plan to coordinate efforts and continue efforts to educate Anthem's network of PCP's.	Substantial	Anthem provided a power point presentation, Kentucky Behavioral Health Symposium that was presented to behavioral health and other health care providers 8/1-8/4/15 in Owensboro, Hazard, Lexington and Elizabethtown. The seminar included covered services, billing codes that included SBIRT codes covered in PCP settings. The seminar also included an overview of new clinical criteria sets of LOCUS, ASAM, CASII and ESCII. Participants included independent practitioners (some from medical/PCP settings), BHSO's, CMHC's, MSG's and Substance Abuse Providers (AODE's). Department of Insurance representatives also attended. This presentation does not address introducing the SBIRT tool to PCPs, it only addressed coding/billing for such services. Policy and Procedure Delivery of Behavioral Health Services includes the Kentucky-specific requirement for working with DBHDID to introduce SBIRT in appropriate PCP settings (page 6). The policy does not state how this is	Anthem will enhance the SBIRT information in the Provider Manual to ensure it is comprehensive and complete. In addition, a focused Provider Notice will be issued to PCPs regarding the SBIRT tool and its use.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH screening by PCPs are fully addressed.		achieved. Onsite staff indicated that meetings with DBHDID to address SBIRT have been infrequent. The MCO has not implemented any independent initiatives, although staff indicated that this topic is covered in provider orientation. **Recommendation for Anthem** Anthem should develop strategies to facilitate SBIRT in PCP settings. **Recommendation for DMS** DMS could consider facilitating a meeting with MCOs and DBHDID to specifically address barriers to and strategies for the implementation of SBIRT among PCPs. **Final Review Determination** No change in review determination.	
The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.	Full-2015			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.	Substantial - This requirement is addressed in the Provider Manual, Coordination of Care Between Physical and Behavioral Health Care and in Policy and Procedure, Monitoring Continuity of Care – Core Process, which addresses an annual process of collecting and analyzing data related to continuity of care. <u>BH/PH Care Coordination File Review Results</u> 4 files were reviewed. 2 of 4 files included a comprehensive assessment. 2 files did not include a comprehensive assessment or care plan; however, in 1 case the member refused and in the other the member could not be contacted. 3 of 3 files for members who were reached included documentation of identification of physical and behavioral health needs and coordination of services among providers. For 2 of these cases, there was no indication that the PCP was contacted for PH needs; the PCP was contacted for the third member. 3 of 3 files of members who were reached included documentation of some information sharing among providers (with consent) and monitoring of diagnosis, treatment and follow up. **Recommendation for Anthem:** The MCO should ensure that members with physical and	Substantial	Includes BH/PH Care Coordination file review summary results This requirement is addressed in the Provider Manual, Coordination of Care Between Physical and Behavioral Health Care Providers and in Policy and Procedure Coordination of Care Between Behavioral Health and Medical Management <u>BH/PH Care Coordination File Review Results</u> 10 files were reviewed for BH/PH care coordination. 2/5 applicable files (i.e. contacted and consented) had a comprehensive assessment documented; 1 file had no assessment and 2 files had incomplete assessment documentation. 2/4 applicable files had a documented care plan. 4/5 applicable files had identification of behavioral health and physical health needs of the member, and coordination of services as appropriate. For 1/5 applicable files, it could not be determined if care was coordinated, since the member termed prior to the date of consent for case management and member's request for a PCP and dental services. There is a 5 month gap	• Anthem will revise policies in order to clearly address expectations and actions to be taken to ensure care coordination efforts are conducted on behalf of the member related to integration of the physical and behavioral health needs. To be developed by July 1, 2016 • Anthem will develop a PCP/Behavioral Health Specialist Provider coordination letter to be faxed or mailed to a member's PCP and/or Behavioral Health Provider. This letter will be used for any member enrolled in a BH Case Management Program, and will be sent after consent to release to the PCP and/or behavioral Health Provider is obtained from the member and/or guardian. To be developed and in production by July 1, 2016. • The above mentioned letter will identify any current providers known to the Anthem CM and will encourage coordination between the providers (upon consent of the member), specifically the importance of notification of medication changes and significant changes in the members treatment plan(s). • All Anthem Members enrolled in a Behavioral Health Complex Case

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	behavioral health needs have coordinated care among providers including PCPs. **MCO Response:** Anthem will ensure that members with physical and behavioral health needs have coordinated care among providers including PCPs. Plan – Initial CM procedure of reaching out to all service providers, including PCP's, will be emphasized and assigned PCP or other PCP's will be identified via PCP assignment or claims encounter data if no encounters from assigned PCP. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements coordination of BH and PH care are implemented.		in documentation, and it is not clear if the member received services or when the member was re-enrolled. There are no subsequent successful contacts with the member. There were no files applicable for discharge planning for hospitalized members. **Recommendation for Anthem** Anthem should ensure that members in case management have documented comprehensive assessments and care planning and care coordination and follow-up as appropriate. **Final Review Determination** No change in review determination.	Management program will have a completed comprehensive assessment, which includes a review of care coordination needs. Monthly Audits by the Anthem Corporate Performance Improvement Team (PIE) team began in January for Complex Case Management cases. The audit includes indicators related to Assessment Care Coordination and PCP communication. The audits scores are calibrated and reviewed monthly with the PIE team, CM Leadership; and the Performance Enhancement team. The first three month of audits (i.e., Jan, Feb, March) for Kentucky are an initial audit period to establish a baseline regarding weaknesses and strengths of the Case Management team. Routine Audits will begin in April 2016. Monthly Audits along with review of performance will continue throughout 2016.
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Substantial - The Provider Manual addresses BH provider referral to PCPs and member consent. The provision of physical health care services by behavioral health providers if licensed to do so was not found in the Provider Manual. Policy and Procedure, Coordination of Care Between Physical and Behavioral Health Care	Minimal	Consistent with last year, Policy and Procedure Coordination of Care Between Physical and Behavioral Health Care Providers addresses required sharing of information between physical and behavioral health providers for the purposes of coordination of care. This corporate document indicates that sharing of information between	On 3/14/2016, P&P: *Coordination of Care Between Physical and Behavioral Health Care Providers* were updated to include KY specific requirements regarding consent. P&P: *Coordination of Care Between Physical and Behavioral Health Care Providers* will be submitted to the Policy and Procedure Oversight Committee in April for review and

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Providers, addresses required sharing of information between physical and behavioral health providers for the purposes of coordination of care. This corporate document indicates that sharing of information between providers for coordination of care does not require member consent unless required by state law. The Kentucky-specific requirement for consent is not referenced. **Recommendation for Anthem:** The MCO should include the Kentucky- specific requirements regarding consent in the Policy and Procedure. The MCO should include the requirements for the provision of physical health care services by behavioral health providers in the Provider Manual. **MCO Response:** Anthem will include Kentucky specific requirements regarding consent in policy and procedure and include the requirements for the provision of physical health care services by behavioral health providers in the Provider Manual. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements are fully addressed.		providers for coordination of care does not require member consent unless required by state law. The Kentucky-specific requirement for consent is not referenced. The Provider Manual does not address the provision of physical health care services by behavioral health providers if licensed to do so. **Recommendation for Anthem** The MCO should include the Kentucky-specific requirements regarding consent in the Policy and Procedure. The MCO should include the requirements for the provision of physical health care services by behavioral health providers in the Provider Manual. **Final Review Determination** No change in review determination.	approval. Coordination of Care Between Physical and
The Contractor shall require that behavioral health	Full-2015			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.				
34.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.	Full-2015			

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The outpatient treatment must occur within seven (7) days from the date of discharge.	Substantial - This transitional care requirement for outpatient visit within seven days of discharge is included in the Provider Manual page 11 and is addressed in Access and Availability-KY. It is also addressed in the 2014 Kentucky UM Program Description, which indicates that the telephonic concurrent review clinician will ensure a follow-up appointment within 7 days of discharge for behavioral health discharges. However, the Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Provider Agreement states that outpatient treatment must occur within 14 days of discharge from inpatient psychiatry services. **Recommendation for Anthem:** The MCO should ensure that provider contracts are consistent with requirements for outpatient treatment within 7 days of date of discharge. **MCO Response:** Anthem will ensure that provider contracts are consistent with requirements for outpatient treatment within 7 days of date of discharge. Plan – Workgroup with BH and provider relations to address any additional contract language in provider agreements and revised provider agreements to be issued in 2015.	Minimal	The Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Provider Agreement continues to state that outpatient treatment must occur within 14 days of discharge from inpatient psychiatry services. Policy and Procedure Delivery of Behavioral Health Services also states in the Kentucky addendum, pages 6-7, that outpatient treatment must occur within 14 days from the date of discharge. The Policy and Procedure Access and Availability - KY addresses the 7-day requirement. The Provider Manual, page 11, addresses this requirement. Policies and procedures, as well as the Provider Manual and provider agreements should be consistent with the contract requirement of 7-day follow-up after discharge. It was not clear during onsite review that all staff were aware of this requirement. **<u>Recommendation for Anthem</u>** Anthem should ensure that policies and procedures, as well as the Provider Manual and provider agreements are	On 3/14/2016, P&P: Delivery of Behavioral Health Services was updated to include KY specific requirements regarding outpatient treatment must occurring within seven (7) days from the date of discharge. P&P: Delivery of Behavioral Health Services will be submitted to the Policy and Procedure Oversight Committee in April for review and approval. Delivery of Behavioral Health Ser The Provider Manual and policy – Access and Availability – KY – both outline the 7-day follow-up after discharge requirement. The Medicaid Provider Agreement (Section 2.10) and the Medicaid Attachment (Section 2.5) state that Provider must be in compliance with the Provider Manual, policies, programs and procedures. In addition, section 2.1 (c) of the Medicaid Attachment has been revised to the 7 day requirement.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Final Review Determination: No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH are fully addressed.		consistent with the contract requirement of 7-day follow-up after discharge. The MCO should ensure that all staff members are aware of requirements. **Final Review Determination** No change in review determination.	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.	Full-2015			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.	Non-Compliance - The MCO provided an untitled draft Policy and Procedure with an effective date of 1/1/14 that addresses Behavioral Health-Court Ordered Services. The MCO should finalize the draft policy that appropriately addresses Court Ordered Services. **MCO Response:** Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – Draft policy will be sent to Policies/Procedures committee for final review and approval. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH are fully addressed.	Non-Compliance	Anthem provided the draft Policy and Procedure for Court-Ordered Services. The MCO indicated that the policy/procedure has been sent to policy committee for expedited approval. Onsite staff provided an update Policy and Procedure document Court Ordered Services-KY that was approved 1/11/16. Requirements are addressed in this policy. **Recommendation for Anthem** The MCO provided a compliant Policy and Procedure approved after the review period. The MCO should ensure implementation of the Policy and Procedure. **Final Review Determination** No change in review determination.	P&P: *Court Ordered Services* will be submitted to the Policy and Procedure Oversight Committee in April for review and approval. Court Ordered Services - KY.docx
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the	Non-Compliance – See Above.	Non-Compliance	Anthem provided the draft Policy and Procedure for Court-Ordered Services. The MCO indicated that the policy/procedure has been sent to policy	P&P: *Court Ordered Services* will be submitted to the Policy and Procedure Oversight Committee in April for review and approval.

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.			committee for expedited approval. Onsite staff provided an update Policy and Procedure document Court Ordered Services-KY that was approved 1/11/16. Requirements are addressed in this policy. **Recommendation for Anthem** The MCO provided a compliant Policy and Procedure approved after the review period. The MCO should ensure implementation of the Policy and Procedure. **Final Review Determination** No change in review determination.	Court Ordered Services - KY.docx
34.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
A. The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law and/or voluntarily admitted to the state psychiatric hospital.	Full-2015			
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law.	Full-2015			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.				
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.	Full-2015			
B. The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive case management services as medically necessary to Members with severe mental illness (SMI) and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.	Full-2015			
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.	Full-2015			
Appropriate follow up by the Behavioral Health Service Provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a	Substantial - Addressed in the Provider Manual and Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid	Minimal	The Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Provider Agreement	On 3/14/2016, P&P: Delivery of Behavioral Health Services was updated to include KY specific requirements

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
state operated or state contracted psychiatric hospital.	Facility Agreement. As noted above, while the Provider Manual indicates follow-up within 7 days, the contract amendment indicates follow-up within 14 days. The MCO provided a spreadsheet of administrative HEDIS rates for Follow-Up After Hospitalization for Mental Illness as of December 2014. The document shows that there is opportunity for improvement for follow-up in 7 days (17.37 %; below NCQA 25th percentile) and at 14 days (29.45%; below NCQA 10th percentile). **Recommendation for Anthem:** The MCO should ensure that the follow up timeframe is consistent in the Provider Manual and provider contract, and evaluate barriers and implement interventions to improved follow-up. **MCO Response:** Anthem will ensure that the follow up timeframe is consistent in the Provider Manual and provider contract, and evaluate barriers to follow up after hospitalization so that strategies can be developed to improve appropriate follow up. Plan - Workgroup with BH and provider relations to address any additional contract language in provider agreements and revised provider agreements to be issued in 2015.		continues to state that outpatient treatment must occur within 14 days of discharge from inpatient psychiatry services. Policy and Procedure Delivery of Behavioral Health Services also states in the Kentucky addendum, pages 6-7, that outpatient treatment must occur within 14 days from the date of discharge. The Policy and Procedure Access and Availability - KY addresses the 7-day requirement. The Provider Manual, page 11, addresses this requirement. Policies and procedures, as well as the Provider Manual and provider agreements should be consistent with the contract requirement of 7-day follow-up after discharge. HEDIS 2015 (measurement year 2014) for Anthem shows the following rates and comparisons to NCQA benchmarks: Follow-up after hospitalization for mental illness within 7 days: Anthem rate – 20.52% Below NCQA average and below the NCQA 25th percentile	regarding outpatient treatment must occurring within seven (7) days from the date of discharge. P&P: Delivery of Behavioral Health Services will be submitted to the Policy and Procedure Oversight Committee in April for review and approval. Delivery of Behavioral Health Ser The Provider Manual and policy – Access and Availability – KY – both outline the 7-day follow-up after discharge requirement. The Medicaid Provider Agreement (Section 2.10) and the Medicaid Attachment (Section 2.5) state that Provider must be in compliance with the Provider Manual, policies, programs and procedures. In addition, section 2.1 (c) of the Medicaid Attachment has been revised to the 7 day requirement

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Anthem will also hire Medical Specialist in June 2015 to phone members and providers after members discharged from hospitals and will track data any trends of any barriers identified to improve adherence and more positive outcomes for members. **Final Review Determination:** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH are fully and consistently addressed and that action is taken to improve follow-up.		Follow-up after hospitalization for mental illness within 30 days: Anthem rate – 37.02% Below NCQA average and below the NCQA 25th percentile These results are noted in the 2015 Medicaid Quality Management Work Plan under the HEDIS tab, however no interventions are noted. Actions to address these findings were discussed onsite, and evidence was provided of outreach after discharge to members who were hospitalized. **Recommendation for Anthem** Anthem should ensure that policies and procedures, as well as the Provider Manual and provider agreements are consistent with the contract requirement of 7-day follow-up after discharge. The MCO should ensure that all staff members are aware of requirements. Barriers to follow-up, such as lack of contact with members, should be explored. The MCO should consider MCO level system interventions if low rates persist, such as dissemination of	

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			appropriate timeframes to providers, discharge planning prior to discharge, and assessment of needs prior to discharge. **Final Review Determination** No change in review determination.	
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.	Full-2015			
34.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);	Full-2015			
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	Full-2015			
C. Identify a method to evaluate the continuity and coordination of care, including member-approved	Minimal - Policy and Procedure, Monitoring Continuity of Care-Core Processes, indicates that	Non-Compliance	Anthem provided corporate policies for Case Manager Role and Functions for	• Anthem will revise policies in order to clearly address expectations and

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
communications between behavioral health care providers and primary care providers;	measures will be developed to monitor continuity and coordination; these have not yet been identified. **Recommendation for Anthem:** The MCO should develop strategies for evaluation and measurement to ensure continuity and coordination and communication. **MCO Response:** Anthem will develop strategies for evaluation and measurement to ensure continuity and coordination, such as information sharing. Plan – Anthem will work with Care Management Services regarding ability to track, including having initial outreach note template added in CareCompass to ensure ability to capture data for evaluation and measurement. **Final Review Determination:** No change in review determination. Anthem should ensure that processes to evaluate the continuity and coordination of care and communication between BH provider and PCPs are developed and implemented.		Complex Case Management, and Health Care Professional Consultation. These policies do not address communications between behavioral health care providers and primary care providers. Policy and Procedure Coordination of Care Between Physical Health and Behavioral Health Care Providers that addresses sharing of information between behavioral health care providers and primary care providers. It does not provide a method for the MCO to evaluate continuity and coordination of care. Policy and Procedure Coordination of Care Between Behavioral Health and Medical Management addresses coordination of physical health and behavioral health staff to coordinate services for individual members with physical health and behavioral health issues. Strategies and methodology to evaluate and monitor continuity and coordination of care, including communications between behavioral health care providers and primary care providers, were not identified in onsite interviews.	actions to be taken to ensure care coordination efforts are conducted on behalf of the member related to integration of the physical and behavioral health needs. To be developed by July 1, 2016 • Anthem will develop a PCP/Behavioral Health Specialist Provider coordination letter to be faxed or mailed to a member's PCP and/or Behavioral Health Provider. This letter will be used for any member enrolled in a BH Case Management Program, and will be sent after consent to release to the PCP and/or behavioral Health Provider is obtained from the member and/or guardian. To be developed and in production by July 1, 2016. • The above mentioned letter will identify any current providers known to the Anthem CM and will encourage coordination between the providers (upon consent of the member), specifically the importance of notification of medication changes and significant changes in the members treatment plan(s). • All Anthem Members enrolled in a Behavioral Health Complex Case Management program will have a completed comprehensive assessment,

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem The MCO should develop strategies for evaluation and measurement to ensure continuity and coordination and communication. **Final Review Determination** No change in review determination.	which includes a review of care coordination needs. Monthly Audits by the Anthem Corporate Performance Improvement Team (PIE) team began in January for Complex Case Management cases. The audit includes indicators related to Assessment Care Coordination and PCP communication. The audits scores are calibrated and reviewed monthly with the PIE team, CM Leadership; and the Performance Enhancement team. The first three month of audits (i.e., Jan, Feb, March) for Kentucky are an initial audit period to establish a baseline regarding weaknesses and strengths of the Case Management team. Routine Audits will begin in April 2016. Monthly Audits along with review of performance will continue throughout 2016. • In addition to the above compliance and quality efforts, Anthem will evaluate the opportunity for developing a "Pay for Performance" or incentive Program for providers who clearly develop and practice coordination of care on behalf of the member. Should the model be adopted, it would be operational within 6 months of adoption. • Anthem will develop a provider

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				communication to be sent to all in network providers on the importance of care coordination and integration of physical health and behavioral health related to members/patients. Anthem will develop and implement an on line provider meeting/training related to care integration. September 2016. • Anthem will also evaluate the opportunity for developing a pilot program working with a provider(s) to co-locate a Primary Care Practitioner in a mental health clinic and/or co-locate a Behavioral Health Care Practitioner in a Primary Care Setting. Anthem will have to assess provider interest as well as "cost-benefit" analysis. The goal would be to assess effectiveness and potentially encourage high volume providers to develop this model as well.
D. Protect the confidentiality of Member information and records; and	Full-2015			
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Full-2015			
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of				

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Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
these evaluations will be provided to the Contractor.				

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Final Findings

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	4	4	11	5
Total Points	12	8	11	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average			**1.29**	

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

Reviewer Decision:

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

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

Final Findings

Behavioral Health Services
Suggested Evidence

Documents

Policies/procedures for:

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

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

Final Findings

Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Reports

Reports of access and availability of BH providers
Provider program capacity/program mapping reports
Evidence of monitoring of compliance with hotline requirements (MCO Report #11)
Evidence of ensuring follow-up after hospitalization for BH services
Evidence of monitoring compliance with BH standards

File Review

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

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
32.1 Pharmacy Requirements				
The Contractor shall administer pharmacy benefits in accordance with this section in addition to other requirements specified in this contract, and in accordance with all applicable State and Federal laws and regulations. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review (ProDUR);	Full-2015			
B. An accounts receivable process;	Full-2015			
C. Retrospective drug utilization review (RetroDUR) services;	Full-2015			
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, an appeals process, Preferred Drug List (PDL), and a Pharmacy and Therapeutics Committee Meeting (P&T);	Full-2015		Includes review of MCO Reports #39 Monthly Formulary Management and #59 Prior Authorizations (see Quarterly Desk Audit Reports)	
E. Pharmacy Provider relations and education, and call center services (member and provider), in addition to provider services specified elsewhere;	Full-2015			
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;	Full-2015			
G. Claims payment services;	New Requirement	Full	The Anthem Pharmacy Services Program Description Medicaid 2015 addresses claims processing, and indicates the responsibility of the pharmacy benefits manager Express Scripts, Inc. (ESI) to oversee the	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			pharmacy network and ensure claims processing standards are followed. The pharmacy benefits manager Express Scripts Network Provider Manual July 2015 addresses this requirement on pages 18-32 and 87-96. Anthem submitted Policy and Procedure Medical CLA-09 Requests for Reimbursement_Direct Claims that addresses paper claims processing.	
H. The Contractor shall maintain, through an online system, appropriate accounts receivable (AR) records for the Department to systematically track adjustments, recoupments, manual payments, and other required identifying AR and claim information;	Substantial - The following documents partially satisfy this requirement: A02 Drug Use Evaluation, WellPoint Pharmacy Services Program Description Medicaid 2014, Express Scripts, Inc. (ESI) Prospective DUR policy & Procedure CQA9008.04, ESI Drug Utilization Review Policy and Procedure 7/28/14, ESI Network Provider Manual 2014. A word document was provided titled, "Process Document for Anthem Medicaid", which briefly explains the claims submission after the 90 day standard electronic submission window. The website referenced below for manual claims is for the ESI pharmacy	Full	This requirement is addressed in the ESI Provider Manual pages 17-18, ESI Network Pharmacy timely Filing Policy, Anthem Policy and Procedure CL0001 Clinical DUR Edits, ESI Prospective DUR Policy and Procedure and policy and procedure A02 Drug Use Evaluation. Onsite staff indicated that network pharmacies use online systems, but staff provided a document entitled Explanation of Paper Claim Processing in ESI Tracking System that includes a screen shot demonstrating how manual claims are represented as Direct Claims in the tracking system versus pharmacy electronic claims identified as CARD claims.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	network pharmacies only (requires login and password): https://host1.medcohealth.com/medco/prc/index.jsp **Recommendation for Anthem:** Although a process appears to exist for the processing of claims outside the 90 day window there appears to be no processing components for paper claims. A policy and procedure for processing paper claims should be provided. **MCO Response:** Anthem will implement the PBM policy and procedure for the processing of paper claims. **Final Review Determination:** No change in review determination. Anthem should ensure that a Policy for processing of paper pharmacy claims is developed, approved, submitted to DMS, and implemented.			
I. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;	New Requirement	Full	This requirement is addressed in the Pharmacy Services Program Description Medicaid 2015, Objectives, page. 4.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Coverage for all drugs for which a federal rebate is available per USC § 139BR-8 unless otherwise directed by the Department;	Full-2015			
K. All hand-written or computer generated/printed Medicaid prescriptions shall require at least one (1) approved tamper-resistant feature to prevent copying; modification or erasure; or counterfeiting. This requirement does not pertain to prescriptions received by fax, telephone, or electronically; and	New Requirement	Full	This requirement is addressed in the Express Scripts Network Provider Manual page 91.	
L. The Contractor shall also assist the Department by participating in and providing support during internal and external audits, including CMS certification of the Kentucky MEMS.	New Requirement	Substantial	This requirement is partially addressed in the Anthem Pharmacy Services Program Description Medicaid, the Amended Restated ESI Contract Amendment 24, which indicates that the pharmacy benefits manager shall cooperate with and support Plan audits. The Policy and Procedure Corrective Action Regulatory Audits_KY addresses adhering to requirement for issues identified by DMS or CMS audit. Policy and Procedure 2015 Vendor Management Oversight-Pharmacy Compliance and Audit addresses MCO audits. **Recommendation for Anthem** Anthem should include participation and support of Department internal and external audits, including CMS certification of the Kentucky MEMS, in policy and procedure.	The policy and procedure will be updated with this information.

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Final Review Determination No change in review determination.	
32.2 Preferred Drug List				
The Contractor shall maintain a preferred drug list (PDL) and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.	Full-2015			
The Contractor shall provide information to its pharmacy and prescribing Providers regarding the PDL, for Members via posting on the web and other relevant means of communication. This PDL shall be updated by the Contractor throughout the year and shall reflect changes in the status of a drug or add or delete drugs, as required.	Full-2015			
32.3 Pharmacy and Therapeutics Committee				
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The P&T Committee shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the PDL or drug formulary. The P&T Committee shall be considered an advisory committee to a public body and thereby making it subject to the Open Meetings Law. The Contractor shall give prior notice to the Department of the time, date and location of the P&T Committee meetings.	Substantial - The following documents partially satisfy this requirement: A43 Pharmacy and Therapeutics Advisory Committee Kentucky, Wellpoint Medicaid Value Assessment Committee (VAC) Meeting Minutes (quarterly), Wellpoint Clinical Review Committee (CRC) Meeting Minutes (quarterly), Anthem P&T Advisory Committee Agenda, P&T Committee members CRC, WellPoint	Full	This requirement is addressed in The Anthem Pharmacy Services Program Description Medicaid pages 6-7, Policy and Procedure A43 Kentucky Pharmacy ad Therapeutics Advisory Committee and the Anthem Pharmacy and Therapeutics Process Charter and Bylaws. Anthem provided committee minutes for the Kentucky Pharmacy and Therapeutics Advisory Committee for June 4, 2015 and December 16, 2015 and quarterly Clinical Review Committee (CRC) minutes. The MCO also provided a	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Pharmacy Services Program Description Medicaid 2014. A word document was provided that describes the meeting announcement process: the announcement is posted for providers on the secured provider's portal prior to the meeting at the web link provided below: https://mediproviders.anthem.com/Documents/KYKY_PTCommitteeNotice.pdf **Recommendation for Anthem:** No P&T Advisory Committee Meeting Minutes were provided for review – no P&T minutes were available for 2014. P&T Advisory Committee Meeting minutes should be maintained and available for review and the creation and maintenance of such minutes should be explicitly prescribed within policies and procedures. Although a meeting announcement process exists, it appears to be done without the support of a policy and procedure. A policy and procedure should exist		meeting announcement for the June 4, 2015 Kentucky Pharmacy and Therapeutics Advisory Committee.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	delineating the meeting notification process. **MCO Response:** Anthem will ensure meeting minutes are maintained and can be produced going forward. Anthem will also update policy and procedure A43 to include information regarding the meeting notification process and maintenance of the meeting minutes for the KY P&T Advisory Committee Meetings. **Final Review Determination:** No change in review determination. Anthem should ensure that a Policy and Procedure and/or Committee Charter is created for the P&T Committee, that the committee meets as needed, and that meeting minutes are prepared and maintained.			
32.4 Point of Sale and Claims Payment				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain ProDUR review edits and apply these edits at the POS.	Substantial - The following documents partially satisfy this requirement: A02 Drug Use Evaluation, WellPoint Pharmacy Services	Full	This requirement is addressed in Policy and Procedure A02 Drug Use Evaluation, Policy and Procedure Anthem Clinical DUR Edits Policy, Anthem Pharmacy Services Program	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Program Description Medicaid 2014, Express Scripts, Inc. (ESI) Prospective DUR policy & Procedure CQA9008.04, ESI Drug Utilization Review Policy and Procedure 7/28/14, ESI Network Provider Manual 2014. A word document was provided titled, "Process Document for Anthem Medicaid", which briefly explains the claims submission after the 90 day standard electronic submission window. The website referenced below for manual claims is for the ESI pharmacy network pharmacies only (requires login and password): https://host1.medcohealth.com/medco/prc/index.jsp **Recommendation for Anthem:** Although a process appears to exist for the processing of claims outside the 90 day window there appears to be no processing components for paper claims. A policy and procedure for processing paper claims should be provided. **MCO Response:** Anthem will		Description pages 7-8, Express Scripts Provider Manual page 95-96. This requirement is also addressed in the Express Scripts document Claims_Electronic_ Overview.	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	implement the PBM policy and procedure for the processing of paper claims. **Final Review Determination:** No change in review determination. Anthem should ensure that a Policy for processing of paper pharmacy claims is developed, approved, submitted to DMS, and implemented.			
32.5 Pharmacy Rebate Administration				
The Affordable Care Act requires states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. The Department or its designated contractor will provide this claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	Full-2015			
38.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization	Full-2015		Includes review of the following MCO	

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.			Reports: #40A Top 50 Psych Drugs by Quantity Reimbursed #40B Top 50 Psych Drugs by Reimbursement #42A Top 50 Prescribers by Reimbursement #42B Top 50 Prescribers of Controlled Drugs by Reimbursement #42C Top 50 BH Prescribers by Reimbursement #43 Top 50 Controlled Drugs by Quantity Reimbursed #44 Top 50 Drugs by MCO Reimbursement #45A Top 50 Drugs by Quantity #45B Top 50 Non PDL Drugs by Reimbursement (see Quarterly Desk Audit Reports)	

KY EQRO ANNUAL REVIEW
January 2016
Period of Review: January 1, 2015 – December 31, 2015
MCO: Anthem Blue Cross and Blue Shield Medicaid

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	6	1	0	0
Total Points	18	2	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
Pharmacy Benefits
Suggested Evidence

Documents

Policies/procedures for:

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

Preferred Drug List
Listing of drugs requiring prior authorization
Pharmacy & Therapeutics Committee description, membership, meeting agendas and minutes
Process for informing members and pharmacy providers of preferred drug list and related information
Process for evaluating the impact of the pharmacy program on members
Prior authorization process
Process for monitoring and managing the pharmacy program

Reports

Evidence of reporting and analysis of the pharmacy program to ensure compliance with Federal and State requirements
Monthly Formulary Management (MCO Report #39)
Prior Authorizations (MCO Report #59)
Top 50 Psych Drugs by Quantity Reimbursed (MCO Report #40A)
Top 50 Psych Drugs by Reimbursement (MCO Report #40B)
Top 50 Prescribers by Reimbursement (MCO Report #42A)
Top 50 Prescribers of Controlled Drugs by Reimbursement (MCO Report #42B)
Top 50 BH Prescribers by Reimbursement (MCO Report #42C)
Top 50 Controlled Drugs by Quantity Reimbursed (MCO Report #43)

Final Findings

Top 50 Drugs by MCO Reimbursement (MCO Report #44)

Top 50 Drugs by Quantity (MCO Report #45A)

Top 50 Non PDL Drugs by Reimbursement (MCO Report #45B)