KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem Blue Cross Blue Shield

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.	
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.	
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 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.	

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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 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	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.

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			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. 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 Kentucky MCO	

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			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 monitor for improvement. **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.	

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			Anthem should ensure that the MCO conducts and documents analysis of available data; presentation to and review of QI activities to by the committees; and linkage of QI activities to findings from multiple quality evaluations once the data and findings are available. Upon the next annual review, IPRO will evaluate the QI PD, QI Work Plan, meeting minutes and other relevant documentation for evidence of same.	
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	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 member, the hope is the member will be interested in further involvement in process improvement.

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			recruit MCO members for participation 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. **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. Upon the next annual review, IPRO will evaluate meeting minutes and other	

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			relevant documentation for evidence of same.	
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 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 continue efforts to recruit MCO members to participate in the QMAC, ensure that QMAC meetings are held as required, ensure that the QMAC	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.

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			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. **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. Upon the next annual review, IPRO will evaluate meeting minutes and other relevant documentation for evidence of same.	
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 that structure and processes meet accreditation requirements.	The QM Workplan will be updated in Q2 to reflect work toward NCQA accreditation in 2-4 years from 1/1/2014 when the business began.

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			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 accreditation to its QM Work Plan, with the goal of accreditation for its Medicaid product line within 2-4 years. **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	

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			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.	
Annually, the Contractor shall submit the QAPI program description document to the Department for review.		Full	This requirement is met by confirmation that annual Report #84 QIPD was submitted in Q3 2014 (July 2014).	
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	

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			psychotropic medications for children and adolescents.	
The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.		Not Applicable	This is not 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.	
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,		Not Applicable	Anthem has not yet completed/approved its first QM Program Evaluation, since the MCO has been operational only since 1/1/2014.	

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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.			The QM Program Evaluation is included as an annual task in the 201 QM Work Plan.	
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.		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.	
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and		Full	Anthem has submitted documentation requested by the EQRO related to PIPs, focused studies and the compliance review.	

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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.			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	
21.4 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.	
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.		Full	Anthem submitted eligible populations, provider and member information and medical records as requested by the EQRO.	
21.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner		Full	There have been no adverse findings for Anthem to date. However, the QM PD addresses EQR	

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in accordance with guidelines established by the Department and EQRO. The Contractor shall:			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.	
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 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; and		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.	
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. 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.	Develop a Policy and Procedure for corrective action plans according to contract requirements in Q3.

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			Recommendation for Anthem Anthem should develop, approve, and implement a Policy and Procedure to address the contract requirements related to Corrective Action Plans. **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 internally. Upon the next annual review, IPRO will evaluate the presence of a Policy and Procedure for submission of corrective action plans to DMS and the EQRO.	
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.	

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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.	
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).	
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.	
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.	
objectives, and		Full	Addressed in the 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.	The 2015 QM workplan will be updated in Q2 to reflect DMS reports due along with the due dates.

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			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.	
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.	
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. 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.	

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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, 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.	
review of written reports from the designated entity on a		Minimal	Addressed in the QM PD, page 8,	The BOD met in Q1 and has another scheduled meeting in Q2

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periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;			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. 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.	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.

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			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. Upon the next annual review, IPRO will review committee meeting minutes and other relevant documentation for evidence of same.	
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 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 QAPI program on an ongoing basis to accommodate review findings and issues of concern		Not Applicable	Addressed in the QM PD, page 5, Scope, Organization Structure and Accountability:	

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within the organization.			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 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.	
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	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.

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			the Kentucky MCO is an agenda topic, minutes reflect the content discussed. **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. Upon the next annual review, IPRO will review committee meeting minutes and other relevant documentation for evidence of same.	
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 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.	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.

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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 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 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.	

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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 2014 QMC meeting preceded the QMAC meeting that was held in 2014, so reporting of QMAC to QMC is not evident. **Recommendation for 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. **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. Upon the next annual review, IPRO will review committee meeting minutes and other relevant documentation for evidence of same.	
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.	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

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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**
			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 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. **Final Review Determination** No change in review determination. Anthem should ensure that the QIC and QMC meet as required and that meeting minutes reflect the committees' fulfilling stated functions.	

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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**
			Upon the next annual review, IPRO will review committee meeting minutes and other relevant documentation for evidence of same.	
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 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	

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			QAPI 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 Appeals, Provider Credentialing, and Provider Services in its QAPI program.		Full	Addressed in the QM PD, page 4, QI Program Goals, page 5, Program Scope, and 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.	
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		Substantial	Resources are addressed in the QM PD, pages 8 & 9 and in Appendix C, Resources and in the QM Work Plan.	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

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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**
not limited to, monitoring and evaluation of Member's care and services, including the care and services of Members with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.			Onsite staff provided an organizational chart that documented 61 staff 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 and improvement initiatives implemented, there is adequate dedicated staff to carry out required activities.	specialists and 2 quality nurses is currently occurring.

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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**
			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. Upon the next annual review, IPRO will review the organizational chart, QI PD and other relevant documentation for evidence of same.	
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. 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.	The 2015 QM workplan will be updated Q2 to reflect due dates for specific tasks and reports.
19.4 QAPI Monitoring and Evaluation				

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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**
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.		Full	Addressed throughout the QM PD, Introduction and Mission, Purpose, QI Program Goals, Program Scope, 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.	
B. 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 and UM Guidelines was evidenced in the MAC meeting minutes. Evaluation of provider compliance could	

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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**
			not be assessed in 2014. This will be completed with HEDIS 2015 reporting.	
Areas identified for improvement shall be tracked and corrective actions taken as indicated.		Not Applicable	Anthem has not yet conducted measurement of provider adherence to guidelines; this will be completed with HEDIS 2015 reporting.	
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.	
C. 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 improvement opportunities. **Final Review Determination** No change in review determination. Anthem should ensure that the QMC and QIC are comprised of appropriate	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 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 teams and 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. Upon the next annual review, IPRO will review meeting minutes other relevant documentation for evidence of same.	
D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.		Full	Anthem submitted its first PIP proposals in September 2014.	
E. 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 evidenced in the MAC 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
			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.	
The guidelines shall be based on valid and reliable medical 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.	
consider the needs of Members;		Full	Addressed in the QM PD, Objectives, Program Methodology, and Key Initiatives,	

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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 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.	
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.	
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.	

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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**
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 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	Kentucky specific requirements will be added to the Procedure Development of Marketing and Member Communications policy in Q2.

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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**
			Materials Approval Process (CMAP); the review of communication to CMAP or 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. **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. Upon the next annual review, IPRO will evaluate the Policy and Procedure for evidence of same.	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on their progress.		Full	The status of innovative programs (Appendix Q) is reported in the Update Innovative Programs – Appendix Q, 1-30-15. This document outlines multiple initiatives, some of which appear to be still in development.	Reports will capture additional detail surrounding innovative programs presented in the RFP.

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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**
			For some of the initiatives in place, such as expedited access to 17P for eligible women, there is not much detail provided regarding how the MCO is working with members and providers to expedite access, reach of the program, challenges and successes, or any modifications to the program that have been necessary . **Recommendation for Anthem** The MCO should include detailed information in the update reports regarding structure, implementation, and challenges/successes of programs as they are implemented.	
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix N, 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		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.	

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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**
measures, the parties agree to amend the previously identified measures.				
Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.		Not Applicable	No measures have been considered for rotation to date.	
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.	
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.	
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. Similarly, the MCO is not yet able to	

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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**
			prepare and submit an annual report or stratify data to assess for disparities.	
20.2 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 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.	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.		Not Applicable	Anthem is reporting HEDIS for the first time in 2015. Anthem will not be able to report on performance trends until reporting year (RY) 2016.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall		Not Applicable	Anthem is reporting HEDIS for the first time in 2015.	

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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**
stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.			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.	
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.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.		Not Applicable	Anthem submits encounters as 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.	
20.3 Accreditation of Contractor by National Accrediting				

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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**
Body				
A Contractor which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.		Not Applicable	Anthem has been operating for only 1 year and has not yet obtained accreditation.	
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.		Not Applicable	Anthem has 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.	The QM Workplan will be updated in Q2 to reflect work toward NCQA accreditation in 2-4 years from 1/1/2014 when the business began.
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristics		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.	

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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 health risks; and the interest of Members in the aspect of care/services to be addressed.			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 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 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		Full	This requirement is met by submission of PIP proposals in September 2014 as noted above.	

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 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.	
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.	
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to behavioral health. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department may require Contractor to (i) implement an additional PIP specific to the Contractor; if findings from an EQR review or audit indicate the need		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.	

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**
for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.				
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.		Full	As described above, Anthem has submitted proposals for the Statewide Collaborative BH PIP and the DMS/EQRO recommended PIP focusing on ED Utilization.	
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.	
A. Topic and its importance to enrolled members;		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, per above.	
C. Goals;		Full	Evidenced in the Aims/Objectives/Study Question for each PIP.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Data sources/collection;		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.	
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.	
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.	
B. Did Members participate in the performance improvement project;		Not Applicable	Anthem's PIPs are in the proposal phase.	
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.	
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.	
E. Is there an executive summary;		Not Applicable	Anthem's PIPs are in the proposal phase.	
F. Do illustrations – graphs, figures, tables – convey information clearly?		Not Applicable	Anthem's PIPs are in the proposal phase.	

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**
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.	
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.	
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.	
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.	
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.	
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than		Not Applicable	Anthem's PIPs are in the proposal phase.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
September 1 of the contract year.				
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.		Full	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.	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Member participation may be excused by the Department upon a showing by Contractor of good faith efforts to obtain member participation. Responsibilities of the Committee shall include:		Minimal	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 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 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 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 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 participate in the QMAC. Once MCO members are recruited, an updated list of QMAC members should be submitted to DMS. **Final Review Determination** No change in review determination Anthem should ensure that members are recruited for the QMAC as planned, meetings are held as required, and minutes reflect the committee fulfilling its required functions. At the next annual review, IPRO will evaluate committee meeting minutes and other related documentation for evidence of same.	
A. Providing review and comment on quality and access standards;		Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The committee 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.	
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 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.	
D. Reviewing Member education materials prepared by the Contractor;		Full	Addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC.	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The committee 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.	
E. Recommending community outreach activities; and		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 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.	Will ensure the QMAC agenda captures involvement in recommending community outreach activities.
F. Providing reviews of and comments on Contractor and Department policies that affect Members.		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	

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**
			in October 2014. The meeting minutes reflect discussion of grievance and appeal procedures.	
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.	
20.8 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.		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 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.	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.		Not Applicable	Not Applicable as above.	
Annually, the Contractor shall assess the need for		Full	Although 2014 was the MCO's first year in	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services.			operation, Anthem conducted a survey 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.	
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.	
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 in conducting the Provider or other special surveys,		Not Applicable	The MCO's first Provider Satisfaction and CAHPS surveys will be conducted 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**
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.				
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.	
37.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of 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.	

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	57	3	8	1
Total Points	171	6	8	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.68**		

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

Final Findings

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

Reports

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

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**
24. General Requirements for Grievances and Appeals				
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.		Full	This requirement is addressed in Member Complaints and Grievances and Member Appeals – Core Process.	
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf. KAR 17:010 Section 4 (18)		Full	This requirement is addressed in the Provider Manual sections 3.2 Medical Necessity Appeals, 3.3 Expedited Appeals (pages 24-25), 4.7 Member Grievances and 9. Provider Grievance Procedures.	
24.1 Grievance and Appeal Policies and Procedures				
The MCO 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 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	This requirement is addressed in Member Complaints and Grievances and Member Appeals – Core Process.	
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a		Full	This requirement is addressed in Member Appeals – Core Process: "Exceptions". This requirement is also addressed in Member Complaints 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**
representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member. KAR 17:010 Section 4 (2), (4) (a) and Section 15 (1)			Grievances and the Member Handbook: Grievances and Medical Appeals pages 44-49.	
A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the appeal. KAR 17:010 Section 4 (4) (a), (5) , (6), and Section 15 (1)		Full	This requirement is addressed in Member Appeals – Core Process: section Policy page 2, with a Kentucky Exception indicating that Kentucky members have 30 days after notice of denial to file an appeal. This requirement is also addressed in the Member Handbook: Grievances and Medical Appeals pages 44-49.	
A. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;		Full	This requirement is addressed in Member Appeals – Core Process: section Procedure 7,8,9,10,11 and 12. The process is evident in submitted MCO reports #27, 28 and 29.	
B. 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		Full	This requirement is addressed in Member Complaints and Grievances page 6. Grievance files are maintained separately from medical records 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**
or appeal;			Quality Management as per onsite staff.	
C. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;		Full	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results This requirement is addressed in Member Appeals – Core Process, section Pre-service Appeals #5, section Post Service Appeals #5 and Handling of Appeals 1.e.i, ii. This requirement is also addressed in Member Complaints and Grievances. <u>Member Grievance File Review Results – Random</u> There were no applicable files among the grievance files that were reviewed. <u>Member Grievance File Review Results – Quality</u> There were no applicable files among the grievance files that were reviewed. <u>Member Appeal File Review Results</u> 10/10 files met this requirement.	
D. 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		Substantial	Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results	Will update the Member Grievance Policy to reflect additional steps for clinical review of potential quality of care concerns within a

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**
expertise;			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 – Random</u> There were no applicable random grievance files. <u>Member Grievance File Review Results – Quality</u> 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. <u>Member Appeal File Review Results</u> 10/10 appeal files included documented	grievance even when the nature of the primary grievance is not quality of care specific.

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**
			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. **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. Upon the next annual review, IPRO will evaluate the Policy and Procedure and conduct a grievance file review to confirm same.	
E. Process for informing Members, orally and/or in writing, about the MCO's Grievance and Appeal Process by making information readily available at the MCO's office, by		Full	This requirement is addressed in the Member Handbook, section Grievances and Appeals pages 44-49, Provider Manual Section 3.2 Medically Necessary	

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**
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;			Appeals and 3.3 Expedited Appeals, Member Complaints and Grievances, and Member Appeals – Core Process, section Responsibilities section 4.	
F. Provide assistance to Members in filing a grievance if requested or needed;		Full	This requirement is addressed in the Provider Handbook page 45 "Filing a Grievance", the Member Handbook page 45, and Member Complaints and Grievances.	
G. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;		Full	This requirement is addressed in Member Complaints and Grievances and Member Appeals – Core Process, section Responsibilities #5.	
The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests an expedited resolution or supports a Member's expedited appeal. 42 CFR 438.410 (b)		Full	This requirement is addressed in Member Appeals – Core Process, section Responsibilities #5 and section Expedited Resolution Appeals #2 and the Provider Manual.	
H. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;		Full	This requirement is addressed in the Member Handbook.	
I. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;		Substantial	Includes Member Grievance Random and Member Grievance Quality file review results	Additional audits of grievance procedures will assist in identifying any missed communication with members.

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**
			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 – Random</u> 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 complaints and Grievances policy will be updated to reflect notices of resolution will be provided in manner to ensure ease of understanding.

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 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. **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.	

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**
			Upon the next annual review, IPRO will evaluate the Policy and Procedure to confirm the update and will conduct a grievance file review to ensure same.	
J. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;		Full	This requirement is addressed in the Member Handbook (pages 45 -49). Member Appeals – Core Process and Member Complaints and Grievances.	
K. Provide for continuation of services, if appropriate, while the appeal is pending; The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420		Full	This requirement is addressed in Member Appeals – Core Process and Member Complaints and Grievances, section Continuation of Benefits.	
The Contractor shall provide benefits until one of the following occurs:		Non-Compliance	The Member Handbook addresses the requirements with the exception of the	Member handbook will be updated Q2 to include missing language regarding "Fourteen

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 Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member; (4) The time period or service limits of a previously authorized service has expired. 42 CFR 438.420 KAR 17:010 Section 4 (14)			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." **Final Review Determination** No change in review determination.	(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". 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 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**
			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. Upon the next annual review, IPRO will evaluate the Member Handbook and Policy and Procedure to ensure same.	
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420		Full	This requirement is addressed in Member Appeals – Core Process, Resolution and Notification #2.v page 21. This requirement is also addressed in the Member Handbook page 49.	
If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished		Full	This requirement is addressed in Member Appeals – Core Process, section	

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**
while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services. 42 CFR 438.424			State Fair Hearing #7 page 23.	
L. Provide expedited appeals relating to matters which could place the Member at risk or seriously compromise the Member's health or well-being; If the Contractor denies a request for an expedited resolution of an appeal, it shall: (1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and (2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file. KAR 17:010 Section 4 (16)		Full	Member Appeals – Core Process addresses the requirement to document all oral requests for appeals in writing. These requirements are also addressed in the Member Handbook and Provider Manual.	

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**
M. Provide written notice of the appeal decision;		Full	This requirement is addressed in Member Appeals – Core Process, section Resolution and Notification #2 page 20.	
N. Provide for the right to request a hearing under KRS Chapter 13B; and		Full	This requirement is addressed in Member Appeals – Core Process, section State Fair Hearing pages 22-23.	
O. Provide for continuation of services, if appropriate, while the hearing is pending. The Contractor shall continue the Member's benefits if all of the following are met: (1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice of action; (2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; (3) the services were ordered by an authorized service provider; (4) the time period covered by the original authorization has not expired; and (5) the Member requests extension of the benefits. 42 CFR 438.420		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)". **<u>Recommendation for Anthem</u>** The MCO should ensure requirements for continuation of benefits while hearing is pending are consistent with Kentucky contract requirements in	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 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**
			policies and procedures. **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. Upon the next annual review, IPRO will evaluate the Policy and Procedure to ensure same.	
The Contractor shall provide benefits until one of the following occurs: (1) The Member withdraws the appeal; (2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action; (3) The Cabinet issues a state fair hearing decision adverse to the Member; (4) The time period or service limits of a previously authorized service has expired.		Non-Compliance	This requirement is addressed in Member Appeals – Core Process on page 19, but the policy differs from the requirement as follows: "Ten (10) [or other state required time frame] calendar days" unless member within the ten day timeframe has requested a State Fair Hearing with continuation of benefits. The ten day timeframe is also included in the State Fair Hearing section of Member Appeals-Core Process on	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 Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
KAR 17:010 Section 4 (14) 42 CFR 438.420			page 23. **Final Review Determination** No change in review determination. Anthem should ensure that the Policy and Procedure, Member Appeals – Core Process, regarding continuation of benefits is updated to reflect the Kentucky-specific requirements and timeframes in both sections. Upon the next annual review, IPRO will evaluate the Policy and Procedure to ensure same.	
If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b). 42 CFR 438.420		Full	This requirement is addressed in Member Appeals – Core Process, Resolution and Notification #2.v page 21. This requirement is also addressed in the Member Handbook.	
If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as		Full	This requirement is addressed in Member Appeals - Core Process, section State Fair Hearing #7 and #8 page 23.	

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**
expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services. 42 CFR 438.424				
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, an administrative hearing officer, judicial appeal, or closure of a file, whichever occurs later.		Substantial	This requirement is addressed for appeal files in Member 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. **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	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 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**
			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. Upon the next annual review, IPRO will evaluate the Policy and Procedures to ensure same.	
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.		Full	This requirement is addressed in Member Appeals –Core Process, section "Procedure" #10 pages 9-10 and Member Complaints and Grievances.	
Documentation regarding the grievance shall be made available to the Member, if requested.		Minimal	This requirement is addressed in Member Appeals –Core Process, section Pre-Service Appeals #9 page 13 and section Post Service Appeals #9 page 14 for appeals; Member Complaints and Grievances does not refer to making documentation regarding the grievance available to the member if requested. **<u>Recommendation for Anthem</u>** The MCO should ensure that policies and	Member Complaints and Grievances policy will be updated in Q2 to refer to making documentation regarding the grievance available to the member if requested

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**
			procedures include the availability of documentation regarding grievances to the member on request. **Final Review Determination** No change in review determination Anthem should ensure that the Policy and Procedure, Member Complaints and Grievances, is updated to indicate that documentation regarding the grievance shall be made available to the member on request. Anthem should ensure that the revised Policy and Procedure is submitted to DMS once approved internally. Upon the next annual review, IPRO will evaluate the Policy and Procedure to ensure same.	
Grievance File Review				
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution. KAR S 17:010 Section 4 (2) (a)		Full	Includes Member Random and Member Quality Grievance file review results This requirement is addressed in Member Complaints and Grievances.	

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 File Review Results – Random 10/10 files included an acknowledgement letter within five days of receipt of the grievance. Member Grievance File Review Results – Quality 10/10 quality files included an acknowledgement letter within five days of receipt of the grievance.	
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. KAR 17:010 Section 4 (2) (b)		Substantial	Includes Member Random and Member Quality Grievance file review results This requirement is addressed in Member Complaints and Grievances. Member Grievance File Review Results – Random 9/10 files included a resolution notice. All 9 resolution letters included required information. 10/10 files were resolved within 30 days. Member Grievance File Review Results – Quality 10/10 files included a resolution notice and resolution within 30 days. All 10 resolution letters included required	Additional audits of grievance procedures will assist in identifying any missed communication with members.

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**
			information. **Recommendation for Anthem** The MCO should ensure that grievance files include notices of resolution of the grievance to the member with all required information. **Final Review Determination** No change in review determination. Anthem should ensure that a resolution letter is issued for all member grievances. Upon the next annual review, IPRO will conduct a grievance file review to ensure same.	
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	Includes Member Random and Member Quality Grievance file review results 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	The Member Complaints and Grievances policy will be updated in Q2 to include Kentucky grievance resolution extension requirements.

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**
			include Kentucky grievance resolution extension requirements in policies and procedures. Member Grievance File Review Results – Random and Quality There were no applicable files in the sample of grievance files reviewed. **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 Procedure to DMS once approved internally. Upon the next annual review, IPRO will evaluate the Policy and Procedures to ensure same.	
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		Full	Includes Member Appeal file review results Member Appeals –Core Process, section	

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**
oral appeals, unless the Member or the service provider requests an expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)			Policy page 2 states "The health plan acknowledges appeals within five (5) business days unless the state mandated time frame is shorter." This policy includes a reference to Kentucky requirement that acknowledgement letters include the expected date of resolution. <u>Member Appeal File Review Results</u> 10/10 files reviewed included timely acknowledgement letters that included the expected date of resolution.	
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. KAR 17:010 Section 4 (7)		Full	Includes Member Appeal file review results This requirement is addressed in Member Appeals-Core Process. <u>Member Appeal File Review Results</u> 10/10 files reviewed had timely resolution within 30 days.	
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		Full	Includes Member Appeal file review results This requirement is addressed in Member Appeals –Core Process, section "Extending the Decision Time Frame"	

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 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)			pages 15-16. Member Appeal File Review Results There were no applicable files in the sample reviewed.	
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing. 42 CFR 438.406 (b) (2)		Full	Includes Member Appeal file review results This requirement is addressed in Member Appeals –Core Process. Member Appeal File Review Results 10/10 files reviewed met this requirement.	
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	Includes Member Appeal file review results This requirement is addressed in Member Appeals –Core Process, section "Pre-service Appeals" page 13 #9 and "Post Service Appeals" page 14 #9 and section "Handling Appeals" 2.b. Member Appeal File Review Results 10/10 files reviewed met this requirement.	
For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions		Full	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**
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)			This requirement is addressed in Member Appeals –Core Process, section "Resolution and Notification". <u>Member Appeal File Review Results</u> 10/10 files reviewed met this requirement.	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and (3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action. 42 CFR 438.408 (e) (2)		Minimal	Includes Member Appeal file review results This requirement is addressed in Member Appeals –Core Process, section "Resolution and 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. **<u>Recommendation for Anthem</u>** The MCO should ensure that the written	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 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**
			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. **<u>Final Review Determination</u>** No 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. Upon the next annual review, IPRO will review the resolution notice template and conduct a file review to ensure same.	
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		Full	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**
make reasonable efforts to provide and document oral notice. KAR 17:010 Section 4 (14) (c)			This requirement is addressed in Member Appeals –Core Process, section "Resolution and Notification" page 20. Member Appeal File Review Results There were no applicable files in the sample reviewed.	
The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay. KAR 17:010 Section 4 (14) (d) and (15)		Full	Includes review results for Member Appeals if expedited This requirement is addressed in Member Appeals –Core Process, section "Extending the decision timeframe" pages 15-16 and Member Handbook page 45. Member Appeal File Review Results There were no applicable files in the sample reviewed.	
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)		Full	Includes review results for Member Appeals if expedited This requirement is addressed in Member Appeals –Core Process, section "Handling of Appeals" page 18. Member Appeal File Review Results There were no applicable files in the	

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**
			sample reviewed.	
24.2 State Hearings for Members				
A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. A Member may request a State Fair Hearing 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 Member's request for a State Fair Hearing must include a copy of the Contractor's final appeal decision. Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.		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. **<u>Recommendation for Anthem</u>** The MCO should include consequences for the MCO of failure to comply with State Fair Hearing requirements in policy/procedure. **<u>Final Review Determination</u>** No change in review determination. Anthem should ensure that the Policy and Procedure, Member Appeals-Core	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 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**
			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. Upon the next annual review, IPRO will evaluate the Policy and Procedure to ensure same.	
27.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that all appeals from Providers are reviewed. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues. Appeals received from Providers that are on the Member's behalf with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals in a written record 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 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.		Minimal	Includes file review summary results for Provider Grievances and Provider Appeals Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeal Narrative (see Quarterly Desk Audit results) These requirements are addressed in CMXX 002 Provider Claim Appeals – KY and KY GAXX 053 Provider Appeals of Utilization Review Determinations, and the Provider Manual.	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 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**
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 quarterly reports to the Department regarding the number, type and outcomes of Provider grievances and appeals. A Provider does not have standing to request a State Fair Hearing for appeals that fall under the scope of this Section.			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.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Anthem The MCO should ensure that provider grievances are appropriately classified and tracked and trended, and resolved within timeframes as per contract. **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. Upon the next annual review, IPRO will evaluate the Policy and Procedure and conduct a file review of provider grievances to ensure same.	
27. 10 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a		Full	This requirement is addressed in the Provider Handbook section 9. Provider Grievance and Payment Dispute	

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**
contract.			Procedures pages 84-89 and section 4.	
37.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.		Substantial	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeal Narrative (see Quarterly Desk Audit results) **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. **<u>Recommendation for Anthem</u>** 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	Recommendations for enhanced reporting on Report 29 will be incorporated Q2 and ongoing thereafter.

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 resolved within 30 days. **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 within 30 days. Upon the next quarterly and annual reviews, IPRO will evaluate the reports to ensure same.	
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. **Final Review Determination** No change in review determination. Anthem should ensure that Policy and Procedures for grievances and appeals	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 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**
			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. Upon the next annual review, IPRO will review the documents to ensure same.	

Final Findings

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	34	6	4	4
Total Points	102	12	4	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.46**		

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

Reviewer Decision:

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

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility

Final Findings

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

Grievance System
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

Reports

Quarterly reports of grievances and appeals

File Review

Member and Provider grievance files for a sample of files selected by EQRO

Member and Provider appeal files for a sample of files selected by EQRO

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

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**
34.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.		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	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 options with the member, and task a Case Manager to complete an in-depth assessment if appropriate.

Final Findings

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

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**
			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. **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. Upon the next annual review, IPRO will evaluate the Policy and Procedure and implementation to ensure same.	

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 disorder screenings, of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's health care needs within ninety (90) days of Enrollment. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.		Minimal	Includes HRA file review results 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	Excerpt from Anthem HCMS- HRA Final Draft Policy <u>PROCEDURE:</u> "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. 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

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 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 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. **Final Review Determination** No change in review determination.	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 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

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 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.	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).

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**
			Anthem should ensure that referrals to care management for pregnant women as a result of the HRA are documented. Upon the next annual review, IPRO will evaluate the Policy and Procedure and conduct an HRA file review to ensure same.	
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire and the survey instrument for both substance use and mental health disorders.		Minimal	Includes HRA file review results 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 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.	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 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,

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**
			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 consider developing, in consultation with the MCOs, either: a standardized HRA tool for use across MCOs, or a list of minimally required contents for	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 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

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-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. **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.	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).

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**
			Anthem should ensure that all HRA outreach is timely and is documented for each member. Upon the next annual review, IPRO will evaluate the Policy and Procedure and conduct an HRA file review to ensure same.	
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.		Substantial	Includes HRA file review results 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 documented tobacco	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 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**
			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. **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 evident. Upon the next annual review, IPRO will evaluate the Policy and Procedure and conduct an HRA file	

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**
			review to ensure same.	
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. **Final Review Determination** No change in review determination.	The HRA logic is designed to trigger members who answer select questions with an affirmative to the Case Management queue, where 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 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**
			At the time of the onsite review, the documents did not contain the required elements and 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. Upon the next annual review, IPRO will evaluate the Policy and Procedure and conduct an HRA file review to ensure same.	
Members shall be offered assistance in arranging an initial visit to their PCP for a		Minimal	Includes HRA file review results	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

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**
baseline medical assessment and other preventative 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.			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. HRA File Review Results 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. **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	member to identify more specifically the need and assist the member with that need. 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, 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 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**
			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. Upon the next annual review, IPRO will evaluate the documents and conduct an HRA file review to ensure same.	
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	Includes review of MCO Report #79 Health Risk Assessments This requirement was met; the MCO submitted four quarterly reports #79 for 2014. The reports include all required elements.	

Final Findings

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	1	2	4	0
Total Points	3	4	4	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			**1.57**	

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

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem

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**
27.2 Provider Credentialing and Recredentialing				
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,		Full	This is addressed in the Credentialing and Recredentialing policy.	
defining the scope of providers covered,		Full	This is addressed in the Credentialing and Recredentialing policy.	
the criteria and the primary source verification of information used to meet the criteria,		Full	This is addressed in the Credentialing and Recredentialing policy.	
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.		Full	This is addressed in the Initial Credentialing, Recredentialing, and Delegation Policies.	
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.		Full	This is addressed in the Credentialing and Recredentialing policy.	
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.		Full	This is addressed in the Credentials Committee Policy and the committee names and physician types.	
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists,		Full	This is addressed in the Recredentialing policy.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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	This is addressed in the Credentialing and Recredentialing policy.	
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.		Full	This is addressed in the Credentialing and Recredentialing policy.	
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.		Full	This is addressed in the Credentialing and Recredentialing policy.	
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in		Full	This is addressed in the Credentialing and Recredentialing policy.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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	This is addressed in the Credentialing and Recredentialing policy.	
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;		Full	This is addressed in the Credentialing and Recredentialing policy. The governing body is the Credentialing Committee.	
C. A review of the credentialing policies and procedures by the formal body;		Full	This is addressed in the Credentialing and Recredentialing policy.	
D. A credentialing committee which makes recommendations regarding credentialing;		Full	This is addressed in the Credentialing and Recredentialing policy.	
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;		Full	This is addressed in the Delegation policy.	
F. Written procedures for the termination or suspension of Providers; and		Full	This is addressed in the Provider Terminations policy.	
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	This is addressed in the Termination and Ongoing Monitoring Policy.	
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:		~~Substantial~~ Full	Includes Credentialing file review summary results	We validate board certification and/or highest level of training. Please provide additional information regarding board

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**
			This is addressed in the Credentialing and Recredentialing policy. Credentialing File Review Results The credentialing file review consisted of 5 PCP and 5 specialist files. 10 of 10 files were compliant. ~~in all areas except for one.~~ ~~Anthem does not specifically verify if the provider has 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. 0 of 10 files were compliant for this requirement.~~ ~~**Recommendation**~~ ~~It is recommended that Anthem verify if their providers have professional board certification, eligibility for certification or graduation from a training program to serve children with special health care needs under the age of twenty one. Anthem should add this requirement to its policies and procedures.~~ **Final Review Determination** The review determination is changed to Full. Upon discussion with DMS, this requirement	certifications for children with special health care needs under the age of twenty one so that we may implement IPRO's recommendation.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			is not applicable.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	
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	This is addressed in the Provider Manual section 8.9 and credentialing application.	
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	
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;		~~Non-Compliance~~ Not Applicable	~~Anthem does not specifically verify if the provider has this certification or training.~~ **Final Review Determination** The review determination is changed to Not Applicable Upon consulting with DMS, this requirement is not applicable.	We validate board certification and/or highest level of training. Please provide additional information regarding board certifications for children with special health care needs under the age of twenty one so that we may implement IPRO's recommendation.
F. Previous five (5) years work history;		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	

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**
G. Professional liability claims history;		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	
I. Current, adequate malpractice insurance, as verified through attestation;		Full	This is addressed in the Provider Manual section 8.9 and credentialing application.	
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;		Full	This is addressed in the Credentialing policy and credentialing application.	
K. Documentation of curtailment or suspension of medical staff privileges;		Full	This is addressed in the Credentialing policy and credentialing application.	
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;		Full	This is addressed in the Credentialing policy and credentialing application.	
M. Documentation of censure by the State or County professional association; and		Full	This is addressed in the Provider Manual and credentialing application.	
N. Most recent information available from the National Practitioner Data Bank.		Full	This is addressed in the Provider Manual. Recommendation and credentialing application.	
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;		Full	This is addressed in the provider credentialing application.	
B. Lack of present illegal drug use;		Full	This is addressed in the provider credentialing application.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. History of loss of license and felony convictions;		Full	This is addressed in the provider credentialing application.	
D. History of loss or limitation of privileges or disciplinary activity;		Full	This is addressed in the provider credentialing application.	
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and		Full	This is addressed in the provider credentialing application.	
F. Applicant attests to correctness and completeness of the application		Full	This is addressed in the provider credentialing application.	
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;		Full	This is addressed in the Provider Manual and credentialing application.	
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and		Full	This is addressed in the Provider Manual and credentialing application.	
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.		Full	This is addressed in the Provider Manual and credentialing application.	
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	Based on a copy of an email from DMS, on site reviews are not required, but if deemed necessary by Anthem or required by NCQA.	
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.		Full	This is addressed in KYPEC-0229-11 Provider Visit Form.	

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 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. **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. Upon the next review, IPRO will evaluate the credentialing process and documentation to ensure same.	The site visit form was updated to address this requirement (AKYPEC-0573-15 March 2015)
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:		Full	Includes Recredentialing file review summary results This is addressed in the Recredentialing policy. Recredentialing File Review Results The recredentialing file review consisted of 5 PCP and 5 specialist files. 10 of 10 files were found to be in compliance with all of the requirements.	
A. A current license to practice;		Full	This is addressed in the Recredentialing policy	

Final Findings

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

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 national practitioner data bank;		Full	This is addressed in the Recredentialing policy and provider credentialing application.	
B. Medicare and Medicaid;		Full	This is addressed in the Recredentialing policy and provider credentialing application.	
C. State boards of practice, as applicable; and		Full	This is addressed in the Recredentialing policy and provider credentialing application.	
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.		Full	This is addressed in the Ongoing Sanctions Monitoring policy as well as the provider credentialing application.	
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.		Non-Compliance	Credentialing process cover sheet not available in 2014. Anthem is investigating for 2015. **Final Review Determination** No change in review determination. Anthem should use the format in Appendix H of the Contract to transmit provider credentialing elements to DMS. Anthem should ensure that a Credentialing Process Cover Sheet is generated for each provider and that it is submitted electronically to DMS' fiscal agent. Anthem should ensure that the process developed and format(s) used are submitted to DMS. Upon the next review, IPRO will evaluate the credentialing process and documentation to	Anthem is developing a process to submit requested credentialing elements in Appendix H. The process will be implemented during 3rd quarter 2015, but is subject to change based on revisions to DMS contract requirements.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			ensure same.	
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.		Full	This is addressed in the Ongoing Sanctions Monitoring policy.	
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.		Full	This is addressed in the Recredentialing policy.	
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.		Full	This is addressed in the HDO policy.	
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.		Full	This is addressed in the Ongoing Monitoring policy.	
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.	We will add language to our policy that indicates that the Department is included in our reporting procedures.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation Anthem should add to its policy language that indicates that the Department is included in its reporting procedures. **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. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.		Full	This is addressed In the Ongoing Sanctions Monitoring policy on page 2.	
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Types.htm http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm		Full	This requirement is addressed in Report #67.	
28.1 Network Providers to be Enrolled				

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's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 or as amended and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, 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 agency, 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		Full	This is addressed in the provider recruitment and retention policy along with a review of the geo access report.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor shall also enroll Psychologists, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Certified Peer Support Providers, Certified Parental Support Providers, and Licensed Clinical Social Workers. 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 and certify 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				

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 provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the OSCAR file provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.		Full	This is addressed in Section 2.21 of the Medicaid Addendum for EPA- 2.21 Laboratory Compliance. Provider shall comply with all requirements of the Clinical Laboratory Improvement Act ("CLIA"), regulations promulgated thereunder and any amendments and successor statutes and regulations thereto.	
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.		Full	This is addressed in the Provider Recruitment and Retention policy.	
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.		Full	This requirement is addressed in the Provider Manual and Initial Credentialing policy.	
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.		Full	This is addressed in Section 2.21 – Medicaid Addendum for EPA.	
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a		Full	Report #81 was provided and supports this	

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**
streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to complete the Registration short form in emergency situations. The Contractor shall, in a format specified by the Department report all out-of-network utilization by Members.			requirement.	
28.3 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 joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of		Full	This is addressed in the Provider Recruitment and Retention Policy.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.				
28.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.		Full	This is addressed in the monthly provider file submission to DMS. File name: Report AN_Provider.	
28.5 Enrolling New Providers and Providers not Participating in Medicaid				
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms		Non-Compliance	This is addressed in the Provider Recruitment and Retention-KY however; it is dated 3/12/15. **Final review Determination**	The Provider Recruitment and Retention policy was put into place to address this requirement.

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**
necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid Provider number.			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.	
28.6 Termination of Network Providers				
The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in suspension, termination, or exclusion from the Medicare or Medicaid program; (ii) has a license, certification, or accreditation terminated, revoked or suspended; (iii) has medical staff privileges at any hospital terminated, revoked or suspended; or (iv) engages in behavior that is a danger to the health, safety or welfare of Members.		Full	This is addressed in the Termination policy.	
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.				
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	DMS has indicated that they will accept the terminations/additions weekly report. DMS will accept the weekly terminations/additions report as fulfilling the 3 and 5 day notifications of termination as required by the contract. However, should Anthem find it	

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**
			necessary to take any actions against a provider in addition to suspension, termination or exclusion, you will be required to notify DMS within 3 business days.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider.		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. **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. Upon the next review, IPRO will evaluate to ensure same.	The Provider Terminations – Primary Care Provider, Specialist and Hospital policy has been updated to include Kentucky, and approval is in process.
In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the Contractor will provide all terminations monthly via the Provider Termination Report as referenced in Appendix K. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.		Full	DMS has indicated that they will accept the terminations/additions weekly report. "DMS will accept the weekly terminations/additions report as fulfilling the 3 and 5 day notifications of termination as required by the contract. However, should Anthem find it necessary to take any actions against a provider in addition to suspension, termination or exclusion, you will be required	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			to notify DMS within 3 business days." Report #69 provided as support of reporting requirements.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) thirty (30) days prior to the effective date of the termination or (ii) within fifteen (15) days of receiving notice.		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. **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. Upon the next review, IPRO will evaluate to ensure same.	The Provider Terminations – Primary Care Provider, Specialist and Hospital policy has been updated to include Kentucky, and approval is in process.
The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.		Full	This is addressed in the Termination policy.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider		Non-Compliance	Anthem referenced its Provider Terminations – Primary Care Provider, Specialist and Hospital policies. However, KY is not	The Provider Terminations – Primary Care Provider, Specialist and Hospital policy has been updated to include Kentucky, and

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
within the previous six months. Such notice shall be mailed the later of the following: (i) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.			addressed in the documentation. An update to the policy was made on 2/24/15. **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. Upon the next review, IPRO will evaluate to ensure same.	approval is in process.

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	77	1	0	6
Total Points	231	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		**2.77**		

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
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem Blue Cross Blue Shield

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**
27.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.		Full	This requirement is addressed in the Provider Manual.	
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	This requirement is addressed in the Provider Manual.	
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:				

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. Maintaining continuity of the Member's health care;		Full	This requirement is addressed in the Provider Manual.	
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;		Full	This requirement is addressed in the Provider Manual.	
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;		Full	This requirement is addressed in the Provider Manual.	
D. Discussing Advance Medical Directives with all Members as appropriate;		Full	This requirement is addressed in the Provider Manual.	
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;		Full	This requirement is addressed in the Provider Manual.	
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and		Full	This requirement is addressed in the Provider Manual.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers		Full	This requirement is addressed in the Provider Manual.	
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	This requirement is addressed in the Provider Manual.	
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable				

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**
arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;		Full	This requirement is addressed in the Access and Availability Policy and is communicated to the providers in the Provider Manual.	
(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	This requirement is addressed in the Access and Availability Policy and is communicated to the providers in the Provider Manual.	
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.		Full	This requirement is addressed in the Access and Availability Policy and is communicated to the providers in the Provider Manual.	
B. Unacceptable				
(1) Office phone is only answered during office hours;		Full	This requirement is addressed in the Access and Availability Policy and is communicated to the providers in the Provider Manual.	
(2) Office phone is answered after hours by a recording that tells Members to leave a message;		Full	This requirement is addressed in the Access and Availability Policy and is communicated to the providers in the Provider Manual.	
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and		Full	This requirement is addressed in the Access and Availability Policy and is communicated to the providers in the Provider Manual.	
(4) Returning after-hours calls outside of thirty (30)		Full	This requirement is addressed in the Access	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
minutes.			and Availability Policy and is communicated to the providers in the Provider Manual.	
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all Covered Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of Medically Necessary services.		Full	This requirement is addressed in the Provider Manual.	
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	This requirement is addressed in the Provider Manual.	
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	This requirement is addressed in the Provider Manual.	
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.		Full	This requirement is addressed in the Access and Availability Policy. Geo Access Reports: PCP access in urban areas (standard: within 30 miles or 30 minutes) = 100% access PCP access in rural areas (standard: within 45 miles or 45 minutes) = 100% access	

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. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four (24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals.		Full	This requirement is addressed in the Provider Manual.	
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department in no fewer number than twenty-five (25%) percent of the Specialists enrolled in the Department's Fee-for-Service program by region; and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes. In the event there are less than five (5) qualified Specialists in a particular region, the twenty-five (25%) shall not apply to that 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	An expanded Geo Access report has been requested to include additional information.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			and percentages of access for all specialty areas. **<u>Final Review Determination</u>** No change in review determination. Anthem should ensure that the Geo Access reports contained the required information regarding specialists. Upon the next review, IPRO will evaluate the Geo Access reports to ensure same.	
D. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.		Full	This requirement is addressed in the Provider Manual.	
E. Access to Hospital care shall not exceed thirty (30) miles or thirty (30) minutes, except in non-urban areas where access time may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.		Full	This requirement is addressed in the Access and Availability Policy as well as in the Geo Access Network documentation. Geo Access Reports In-patient hospitals in urban areas (standard: 1 within 30 miles or 30 minutes) = 100% access In-patient hospitals in rural areas (standard: 1 within 60 minutes) = 99.6% access	
F. Access for general dental services shall not exceed sixty (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48)		Full	This requirement is addressed in the Access and Availability Policy as well as in the Geo Access Network documentation. Geo Access Reports:	

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**
hours for urgent care.			General Dentists (standard: not to exceed 60 miles or 60 minutes) = 100% access	
G. Access for general vision, laboratory and radiology services shall not exceed sixty (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.		Full	This requirement is addressed in the Access and Availability Policy as well as in the Geo Access Network documentation. Geo Access Reports: Vision (standard: 1 within 60 miles or 60 minutes) = 99.9% access Labs (standard: 1 within 60 miles or 60 minutes) = 99.9% access in urban areas and 95.3% access in rural areas Radiology (standard: 1 within 60 miles or 60 minutes) = 100% access in urban areas and 99.4% access in rural areas	
H. Access for Pharmacy services shall not exceed sixty (60) miles or sixty (60) minutes or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.		Full	This requirement is addressed in the Access and Availability Policy as well as in the Geo Access Network documentation. Geo Access Reports: Pharmacy services (standard: 1 within 60 miles or 60 minutes) = 100% access in urban and rural areas	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;		Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
B. FQHCs and rural health clinics;		Full	This requirement is addressed in the Provider	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recruitment and Retention Policy.	
C. The Kentucky Commission for Children with Special Health Care Needs; and		Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
D. Community Mental Health Centers		Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.		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 that Anthem have the Provider Recruitment and Retention Policy formally approved. **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. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	5/13/15 – Approval for the update to Provider Recruitment and Retention Policy is in process which will address this requirement
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				

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**
Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.		Full	This requirement is addressed in the plan's Provider Agreement with the Kentucky Department of Public Health.	
B. Provide reimbursement at rates commensurate with those provided under Medicare.		Full	This requirement is addressed in the plan's Provider Agreement with the Kentucky Department of Public Health.	
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.		Full	This requirement is demonstrated in the Provider Recruitment and Retention Policy.	
The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.		Full	This requirement is demonstrated in the Provider Recruitment and Retention Policy.	
28.8 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix G that demonstrates that the Contractor has an adequate network that meets the Department's		Full	This requirement is addressed through the plan's submission of its Geo Access reports. The plan submitted their response to the	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
standards in Section 28.7. The MCO shall notify the Department, in writing, of any anticipated network changes that may impact network standards.			notice of corrective action from the Department for Medicaid Services that addresses network changes.	
The Contractor shall update this information to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.		Full	This requirement is addressed in the Access and Availability Policy.	
28.9 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 the Department shall notify the other of this situation and within fifteen (15) business days the Contractor shall submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time- frames to correct the deficiency.		Full	This requirement is addressed in the Access and Availability Policy.	
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	This requirement is addressed in the Provider Recruitment and Retention Policy.	
30.1 Medicaid Covered Services				
The Contractor shall provide, or arrange for the provision		Full	This requirement is addressed in the Provider	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.			Manual.	
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.		Full	This requirement is addressed in the Provider Manual.	
After the Execution Date, and the adjustment for ACA compliance, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2 and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.		Full	This requirement is addressed in the Single Case Agreement Process, Out of Area-Out of Network Care Policy and in the Non-Covered and Cost Effective Alternative Services documentation.	
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 properly completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.		Full	This requirement is addressed in the Provider Manual.	
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status,		Full	This requirement is addressed in the Provider Manual.	

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**
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.				
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.		Full	This requirement is addressed in the Single Case Agreement Process, Out of Area-Out of Network Care Policy and in the Non-Covered and Cost Effective Alternative Services documentation.	
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	This is addressed in the Provider Manual and the Member Handbook.	
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).		Full	This requirement is addressed in the Emergency Services Core Process and is communicated to the providers in the Provider Manual. This requirement is communicated to the members in the Member Handbook.	
32.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be		Full	This requirement is addressed in the Emergency Services Core Process and is	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
received outside the Contractor's Network, in compliance with 42 CFR 438.114.			communicated to the providers in the Provider Manual.	
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	This requirement is addressed in the Emergency Services Core Process. This requirement is communicated to the providers in the Provider Manual.	
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.		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. **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. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	5/13/15 – Approval for the update to Provider Recruitment and Retention Policy is in process which will address this requirement
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:				

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Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
D. Maternity care for Members under 18 years of age;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
E. Immunizations to Members under 21 years of age;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
F. Sexually transmitted disease screening, evaluation and treatment;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
G. Tuberculosis screening, evaluation and treatment;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
I. Chiropractic services; and		Full	This requirement is addressed in the Access to Health Specialists Policy.	
J. Women's health specialists.		Full	This requirement is addressed in the Access to Health Specialists Policy.	
32.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are		Full	This requirement is addressed in the Access to Health Specialists Policy. This requirement is communicated to the providers in the Provider	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
described in Appendix I to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.			Manual.	
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under 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	This requirement is addressed in the Provider Manual.	
All information shall be provided to the Member in a confidential manner. Appointments for counseling and medical services shall be available as soon as possible with in a maximum of 30 days. If it is not possible to provide complete medical services to Members less than 18 years of age on short notice, counseling and a medical appointment shall be provided right away preferably within 10 days. Adolescents in particular shall be assured that Family Planning Services are confidential and that any necessary follow-up will assure the Member's privacy.		Substantial	The requirement that all information be provided to the member in a confidential manner is addressed in the Provider Manual. The requirement for 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. **Final Review Determination**	5/20/15 – Access and Availability policy was approved on 5/18/2015.

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**
			No change in review determination. Anthem should ensure that the Policy and Procedure is approved and once approved, is submitted to DMS. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem Blue Cross Blue Shield

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	61	4	0	0
Total Points	183	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		**2.94**		

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
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
Geo Access network reports and maps (MCO Report #12A) for:

- Primary care
- Specialty care
- Emergency care
- Hospital care

Final Findings

- 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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

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**
20.6 Utilization Management				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.		Full	MCO addresses this in the UM Program Description.	
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	MCO addresses this in the UM Program Description.	
The description shall include the scope of the program;		Full	MCO addresses this in the UM Program Description.	
the processes and information sources used to determine service coverage;		Full	MCO addresses this in the UM Program Description.	
clinical necessity, appropriateness and effectiveness;		Full	MCO addresses this in the UM Program Description.	
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;		Full	MCO addresses this in the UM Program Description.	
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.		Full	This is addressed in policy Pre-Certification of Requested Services – Core Process pages 9 and 11.	
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.		Full	This is addressed in the UM Program Description page 4. MCO has not done an annual update to this date due to its entry into KY Managed Care 1/1/14.	

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 UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director or the QI Committee.		Full	This is addressed in the UM Program Description page 6.	
The Contractor shall adopt Interqual, Milliman or other nationally recognized standards and criteria, for Medical Necessity review which shall be approved by the Department.		Full	This is addressed in the UM Program Description page 10. This is also addressed in policy Clinical Criteria for Utilization Management Decisions – Core Process pages 1 and 2.	
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.		Full	This is addressed in policy Clinical Criteria for Utilization Management Decisions – Core Process.	
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.		Full	This is addressed in policy Inter-Rater Reliability (IRR) Assessments.	
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.		Full	Includes UM file review results This is addressed in the UM Program Description. <u>UM File Review</u> 10 UM files were reviewed. 10 of 10 were NA due to the nature of the denial.	
The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has		Full	This is addressed in the UM Program Description page 12. <u>UM File Review</u> 10 of 10 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**
appropriate clinical expertise in treating the Member's condition or disease.				
The reason for the denial shall be cited.		Full	This is addressed in the UM Program Description page 12. UM File Review 10 of 10 were compliant.	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.		Full	This is addressed in the UM Program Description page 15.	
The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions.		Full	This is addressed in the UM Program Description page 15.	
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. **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.	*Added to **HCMS Policy and Procedure-Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process - Core Process** ***new*** Added to the **UM Program Description, Section: Criteria Selection and Implementation** "Any changes to prior authorization requirements must be approved by DMS."

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**
			Upon the next review, IPRO will evaluate the Policy and Procedure and Program Description to ensure same.	
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	This is addressed in the UM Program Description page 31. Also addressed in policy Utilization Management – Medicaid Delegation and Oversight.	
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	This is addressed in the UM Program Description page 15.	
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	This is addressed in policy Clinical Criteria for Utilization Management Decisions – Core Process.	
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	This is addressed in the UM Program Description page 4.	
F. The Contractor shall only provide coverage for randomized and controlled Phase III and Phase IV clinical trials.		~~Full~~ Not Applicable	This is addressed in policy Clinical Trial Related Drugs and/or Services Coverage – KY. **Final Review Determination** The review determination is changed to Not Applicable.	

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**
			DMS has indicated that this requirement is not applicable.	
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	This is addressed in the UM Program Description page 4.	
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.		Full	This is addressed in the UM Program Description pages 26 and 27.	
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.		Full	This is addressed in the UM Program Description pages 10 and 11.	
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.		Full	This is addressed in the UM Program Description pages 26 and 31.	
The UM program will be evaluated by DMS on an annual basis.		Substantial	Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit results). MCO states that the UM Program was submitted to DMS for review. DMS confirmed receipt as part of the Readiness Review. The Program Description does not reference required annual submission to DMS.	**Added to the <u>UM Program Description, Section: "Evaluation of the UM Program" p. 34</u>** "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

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**
			Recommendation for Anthem The MCO should add language into its policies and procedures that the UM Program Evaluation is submitted to DMS annually. **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. Upon the next review, IPRO will evaluate the Policy and Procedure and Program Description to ensure same.	required."
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:		Full	This is addressed in the UM Program Description page 15.	
(a) The action the Contractor has taken or intends to take;		Full	This is addressed in policy Healthcare Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
(b) The reasons for the action in clear, non-		Full	This is addressed in policy Healthcare	

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**
technical language that is understandable by a layperson;			Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
(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. UM File Review 10 of 10 were NA due to the type of denial. **Recommendation for Anthem** Anthem should add this language to their policy. **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. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	**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, 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
(d) The Member's right to appeal;		Full	This is addressed in policy Healthcare Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
(e) The Member's right to request a State hearing;		Full	This is addressed in policy Healthcare Management Services Denial Core Process. UM File 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**
			10 of 10 were compliant.	
(f) Procedures for exercising Member's rights to Appeal or file a Grievance;		Full	This is addressed in policy Healthcare Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
(g) Circumstances under which expedited resolution is available and how to request it; and		Full	This is addressed in policy Healthcare Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
(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	This is addressed in policy Healthcare Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
The Contractor must give notice at least: A. Ten (10) days before the date of 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.		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
2. A signed written Member statement requesting service termination or giving information requiring		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
termination or reduction of services (where he understands that this must be the result of supplying that information);				
3. The Member's admission to an institution where he is ineligible for further services;		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
4. The Member's address is unknown and mail directed to him has no forwarding address;		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
5. The Member has been accepted for Medicaid services by another local jurisdiction;		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
6. The Member's physician prescribes the change in the level of medical care;		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
C. The Contractor must give notice on the date of the 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.	**Revised language in policy <u>Healthcare Management Services Denial-Core Process</u> for Kentucky et al, <u>Exceptions: Kentucky</u>** *"Anthem will give notice on the date of the Action*

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 the requirement for Kentucky Medicaid, specifically, is approved internally, and once approved, submitted to DMS. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	*when the Action is a denial of payment"*
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.		Full	This is addressed in policy Healthcare Management Services Denial Core Process. UM File Review 10 of 10 were compliant.	
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. UM File Review 10 of 10 were NA. No denials were on extension. **Final Review Determination** No change in review determination.	**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*

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**
			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. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.		Full	This is addressed in policy Healthcare Management Services Denial Core Process.	
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	This is addressed in policy Healthcare Management Services Denial Core Process.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

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	45	3	0	2
Total Points	135	6	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.82**		

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

Reviewer Decision:

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

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

Final Findings

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

Documents

Policies/procedures for:

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

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

Reports

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

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

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**
36. Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix L, 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 six (6) months to provide a new or revised program. This plan shall include, at a minimum:		Full	This requirement is addressed in Anthem's SIU Fraud Plan.	
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;		Full	This requirement is addressed in Anthem's SIU Fraud Plan, the Compliance Orientation 2014 Training, and 2014 Medicaid Compliance Refresher - Section 3.2 and within the Standards of Ethical Business Conduct documentation.	
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;		Full	This requirement is addressed in the Regulatory Market Manager and Plan Compliance Officer Job Summaries as well as in the Kentucky Plan Compliance Committee Charter - Agendas and Minutes.	
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;		Full	This requirement is addressed in the Compliance Officer and Associates New Hire Introduction to Healthcare Fraud & Abuse, the Compliance Orientation 2014 Training,	

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**
			2014 Medicaid Compliance Refresher - section 2.11, the Standards of Ethical Business Conduct, Monthly Fraud Tips and within the MSIU presentation at August 2014 Town Hall. Training for subcontractors was submitted in the Scion Dental Provider Orientation Presentation - Fraud and Abuse, and eyeQuest Fraud, Waste and Abuse Policy and Manual for Provider Education. Training materials for providers included the Provider Education and Communication Policy, Kentucky Provider Manual, Kentucky Provider Orientation and Update presentations and webinar attendance tracking lists. Training materials for members included the SIU Fraud Plan Kentucky and the Kentucky Medicaid Member Handbook.	
D. Effective lines of communication between the compliance officer and the organization's employees;		Full	This requirement is addressed in the 2014 Compliance Refresher Training and Compliance Orientation Training.	
E. Enforcement of standards through disciplinary guidelines;		Full	This requirement is addressed in the Standards of Ethical Business Conduct.	
F. Provision for internal monitoring and auditing of the member and provider;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
G. Provision for prompt response to detected offenses, and for development of corrective action		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
initiatives relating to the Contractor's contract;				
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	This requirement is addressed in the SIU Fraud Plan Kentucky. The ZIP Report #15 – Quarterly Subcontractor Monitoring Report provides evidence of compliance with this requirement.	
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in the ZIP Report # 72 – Member Violations Letters and Collections and in Report # 71 – Provider Outstanding Account Receivables.	
K. Contractor shall provide procedures for appeal process;		Full	This requirement is addressed in the Provider Claim Appeals Kentucky Policy, the Member Complaints and Grievances Policy, and in the Member Appeals Core Process.	
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;		Full	This requirement is addressed in Report # 73 – Explanation of Member Benefits (EOMB).	
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. **Final Review Determination** No change in review determination.	Anthem will incorporate a card sharing process into the Fraud Plan

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			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. Upon the next review, IPRO will evaluate the SIU Fraud Plan Kentucky to ensure same.	
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	This requirement is addressed in Report #75 SUR Algorithms.	
O. Contractor shall follow cases from the time they are opened until they are closed; and		Full	This is addressed in the MSIU Desk Reference. MSIU's Corporate Investigations Management System (CIMS) is a database to track, update and report activities of the department.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky. November 2014 SAS Fraud Framework training at DMS – Anthem states "Anthem attendee listing sent to DMS and location information received from DMS"	
The plan shall be made available to the Department for review and approval.		Full	This is addressed by MCO's "Fraud Plan – filed with DMS in 2013" and DMS confirmed receipt. **Recommendation for Anthem** Anthem should add to its Policies and Procedures that the plan will be submitted to	We will incorporate this requirement into the Fraud Plan

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			DMS for review and approval.	
9.1 Administration/Staffing				
The Contractor shall provide the functions and positions listed below and ensure a sufficient number of qualified individuals to adequately provide for the MCO's enrollment or projected enrollment.				
A Compliance Director who shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to MCOs and oversee the MCO's compliance with the laws and Contract requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between MCO leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee MCO implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.		Full	This requirement is addressed in Anthem's Compliance Officer job summary and Regulatory Market Manager job summary. Anthem stated that the "RMM (Regulatory Market Manager) serves as the primary health plan contact for the Commonwealth."	
A Program Integrity Coordinator who shall coordinate, manage and oversee the MCO's Program Integrity unit to reduce fraud and abuse of Medicaid services.		Full	This requirement is addressed in the Fraud Plan organization chart as well as in the Program Integrity Governance presentation.	
37.15 Ownership and Financial Disclosure				

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The 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	Includes review of individual disclosures 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). <u>Annual Disclosure File Review Results</u> 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.	The following process will be implemented to meet the recommendation: • 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 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**
			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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	

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**
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;		Minimal	Includes review of individual disclosures 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). <u>Annual Disclosure File Review Results</u> 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.	The following process will be implemented to meet the recommendation: • 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 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**
			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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	
B. The name of any other entity receiving		Minimal	Includes review of individual disclosures	The following process will be implemented

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**
reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;			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). 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**	to meet the recommendation: • 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 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**
			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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions		Minimal	Includes review of individual disclosures Anthem corporate parent company, Anthem	The following process will be implemented to meet the recommendation: • A notice will be sent to the current

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**
totaling more than $25,000 during the immediately preceding twelve-month period;			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). <u>Annual Disclosure File Review Results</u> 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. **<u>Recommendation for Anthem</u>** Anthem should ensure that all applicable subcontractors are registered with the	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 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**
			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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any		Minimal	Includes review of individual disclosures Anthem corporate parent company, Anthem	The following process will be implemented to meet the recommendation: • A notice will be sent to the current

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**
Subcontractor, during the immediately preceding five-year period;			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). <u>Annual Disclosure File Review Results</u> 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. **<u>Recommendation for Anthem</u>** Anthem should ensure that all applicable subcontractors are registered with the	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

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Program Integrity (*See Final Page for Suggested Evidence*)				
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			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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	
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		Minimal	Includes review of individual disclosures Anthem corporate parent company, Anthem Kentucky, and all subcontractors who provide	The following process will be implemented to meet the recommendation: • A notice will be sent to the current subcontractors outlining the

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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;			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). <u>Annual Disclosure File Review Results</u> 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. **<u>Recommendation for Anthem</u>** Anthem should ensure that all applicable subcontractors are registered with the Kentucky SOS; that all registered contractors	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 Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			have 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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	
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	Includes review of individual disclosures Anthem corporate parent company, Anthem Kentucky, and all subcontractors who provide services related to claim and/or payment	The following process will be implemented to meet the recommendation: • A notice will be sent to the current subcontractors outlining the recommendation and giving them an

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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**
			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). <u>Annual Disclosure File Review Results</u> 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. **<u>Recommendation for Anthem</u>** Anthem should ensure that all applicable subcontractors are registered with the Kentucky SOS; that all registered contractors have Officers registered/listed on the	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

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			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. **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. Upon the next review, IPRO will evaluate the subcontractor contracts and conduct a review of annual disclosures to ensure same.	
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		Full	Anthem indicated that "There have been no real changes of ownership, only an Annual Disclosure submission for WellPoint's name change to Anthem."	

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Program Integrity (*See Final Page for Suggested Evidence*)				
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contract that may be impacted by the change in ownership including management and staff.				
State Contract, Appendix L				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff that shall with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and ongoing basis;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
B. Written policies, procedures, and standards of conduct that demonstrate the organization's commitment to comply with all applicable federal and state regulations and standards;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
D. The staff consists of a compliance officer in addition to auditing and clinical staff;		Full	This requirement is addressed through the submission of the Compliance Department organizational chart.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(1) Multi-State fraud or problems of national scope,		Full	This requirement is addressed in the SIU	

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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**
or Fraud or Abuse crossing partnership boundaries;			Fraud Plan Kentucky.	
(2) High dollar amount of potential overpayment; or		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and		Full	This requirement is addressed in the SIU Fraud Plan Kentucky, Monthly FWA Tips, in the Town Hall MSIU Overview presentation and in the 2014 Medicaid Compliance Refresher: section 2.11.	
G. Contractor attends any training given by the Commonwealth/Fiscal Agent, its designees or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.		Full	This requirement is addressed in the SIU Fraud Plan Kentucky and the quarterly MFCU agenda. Anthem attended November 2014 SAS Fraud Framework training at DMS.	
FUNCTION: The 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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	

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Program Integrity (*See Final Page for Suggested Evidence*)				
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record reviews;				
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
D. Initiate appropriate administrative actions to collect overpayments;		Full	This requirement is addressed in the Overpayments Policy May 2014.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
F. Initiate and maintain network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;		Minimal	During 2014 Anthem distributed a monthly Fraud Tips to all Anthem Kentucky Medicaid associates. The MSIU Monthly Dashboard & Plan Report was cited as 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. **Final Review Determination** No change in review determination. Anthem should ensure that this requirement is incorporated into the SIU Fraud Plan Kentucky.	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.

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Program Integrity (*See Final Page for Suggested Evidence*)				
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			Anthem should submit the revised Plan to DMS once final. Anthem should ensure that all vendors and providers receive FWA newsletters/ information. Upon the next review, IPRO will evaluate the Fraud Plan and newsletters and information provided to vendors and providers to ensure same.	
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
I. Provide for internal monitoring and auditing of Contractor and its subcontractors; and supply the Department with quarterly reports or as-requested basis on its activity or ad hocs as necessary;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky as well as in Report #15 – Subcontractor Monitoring Report.	
J. Being subject to on-site review and fully comply with requests from the Department to supply documentation and records;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
K. Create an accounts receivable process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the Department;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky as well as in Report #71 Provider Outstanding Account Receivables.	

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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, there should be a Policy and Procedure to address this. **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. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	We will incorporate the requirement into our existing Overpayments policy
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	This requirement is addressed in Report #27 – Grievance Activity and Report #28 – Appeal Activity.	
N. Conduct regularly 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	This requirement is addressed in the SIU Fraud Plan Kentucky and Reports #76 and #77 Member Fraud, Waste, and Abuse.	
O. Conduct onsite and desk audits of Providers and		Full	This requirement is addressed in the SIU	

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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**
report the results, including identified overpayments and recommendations to the Department;			Fraud Plan Kentucky.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
Q. Designate a contact person to work with investigators and attorneys from the Department and OIG;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in Report #73 Explanation of Member Benefits (EOMB) and the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in Report #75 SUR Algorithms and the SIU Fraud Plan Kentucky.	
U. Collect administratively from Members for overpayments that were declined prosecution, for Medicaid Program Violations (MPV);		Full	This requirement is addressed in Report # 72 – Member Violation Letters and Collections.	

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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	Anthem addressed this requirement through the submission of their Fraud Plan to DMS for approval at implementation.	
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	This requirement is addressed in the Weekly Provider Adds and Terms Reports – Health Plan which states "DMS has confirmed that this report meets the requirement ".	
X. Recover overpayments from Providers and identify Providers for pre-payment review as a result of the Provider's activities;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky and the Overpayments Policy May 2014.	
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. **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. Upon the next review, IPRO will evaluate the Fraud Plan to ensure same.	We will incorporate this language into our Fraud Plan
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.		Non-Compliance	Anthem did not have a policy in place during 2014 to address this requirement. **Final Review Determination** No change in review determination.	We will incorporate this language into our Plan Compliance Officers policy

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Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations.			Anthem should ensure that this requirement is incorporated into the Plan Compliance Officers Policy. Anthem should submit the updated Policy and Procedure to DMS. Upon the next review, IPRO will evaluate the Policy and Procedure to ensure same.	
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and with copy to the Department and OIG.		Full	This requirement is addressed in Reporting Suspected Child, Elder, and Partner Abuse Procedure.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
B. The PIU should review background information and MIS data; however, the preliminary inquiry		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	

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should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;				
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
E. The OIG will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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;				

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H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, the OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend 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;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky. Anthem states that there is a "Process in place to suspend provider payments upon notification from DMS".	
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	Includes Program Integrity File Review Results This requirement is addressed in the SIU Fraud Plan Kentucky. <u>Program Integrity File Review</u> 1 member and 6 provider files were reviewed. 7 of 7 files were fully compliant with the requirements. 4 of 7 files contained a date of completion, while 3 files remained open. 0 of 7 files pertained to overpayment.	

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			7 of 7 files were found to be 'Not Applicable' under standard (13) "Any other elements identified by CMS for fraud referral". No other elements were identified.	
(1) Name and address of subject,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(2) Medicaid identification number,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(3) Source of complaint,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(4) State the complaint/allegation,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(5) Date assigned to the investigator,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(6) Name of investigator,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(7) Date of completion,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(8) Methodology used during investigation,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(10) Attach all exhibits or supporting documentation,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(11) Include recommendations as considered necessary, for administrative action or policy		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	

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revision,				
(12) Identify overpayment, if any, and include recommendation concerning collection,		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
(13) Any other elements identified by CMS for fraud referral.		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
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	This requirement is addressed in Report #76 Provider Fraud Waste Abuse Report, Report #77 Member Fraud Waste Abuse Report and Report # 81: Par and Non-Par Provider Participation.	
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	This is addressed in the MSIU Desk Reference CIMS as well as in the SIU Fraud Plan Kentucky.	
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.		Full	This requirement is addressed in the Provider Claim Appeals Kentucky Policy, the Member Complaints and Grievances Policy and the Member Appeals Core Process.	
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		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the OIG.				
The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:		Full	Details below.	
(1) PIU Case number;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and the SIU Fraud Plan Kentucky.	
(2) OIG Case number (if one has been assigned);		Not Applicable	The OIG field was not part of report 76 or 77.	
(3) Provider/Member name;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(4) Provider/Member number;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(5) Date complaint received by Contractor;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(6) Source of complaint, unless the complainant prefers to remain anonymous;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(7) Date opened and name of PIU investigator assigned;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(8) Summary of complaint;		Full	This requirement is addressed in Report #76	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);		Not Applicable	This element is not listed in the DMS-defined reporting format for the following reports: Report #76 Provider FWA Report #77 Member FWA SIU Fraud Plan Kentucky (Fraud, Waste & Abuse Plan State of Kentucky (10/29/2013) pages 116-117 **Recommendation for DMS** DMS should revise the report templates for Reports #76 and #77 to include this requirement.	
(10) PIU action taken and date (only provide the most current update);		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(11) Amount of overpayment (if any) and time span;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(12) Administrative actions taken to resolve findings of completed cases;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(13) The overpayment required to be repaid and overpayment collected to date;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(14) Describe sanctions/withholds applied to Providers/Members, if any;		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			in the SIU Fraud Plan Kentucky.	
(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	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(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	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
(17) Make MIS system edit and audit recommendations as applicable.		Full	This requirement is addressed in Report #76 Provider FWA, Report #77 Member FWA and in the SIU Fraud Plan Kentucky.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, and maintain records including, but not limited to, ownership disclosure for all Providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;		Full	This is addressed in the 2013 SIU Fraud Plan on page 117.	
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
C. Backup, store and be able to recreate reported		Full	This requirement is addressed in the	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
data upon demand for the Department and the OIG;			SIU Fraud Plan Kentucky.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
E. Produce records in electronic format for review and manipulation by the Department and the OIG;		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems;		Not Applicable	DMS has indicated this item is not applicable.	
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	This requirement is addressed in the SIU Fraud Plan Kentucky.	
H. Fully cooperate with the Department, OIG, the United States Attorney's Office and other law enforcement agencies in the investigation of Fraud or Abuse cases; and		Full	This requirement is addressed in the SIU Fraud Plan Kentucky.	

Final Findings

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	101	0	8	4
Total Points	303	0	8	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Program Integrity
Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
Monthly state reporting
Quarterly Program Integrity Reports

File Review

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

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**
32.1 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 J. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.		Full	This requirement is addressed in the Policy and Procedure EPSDT Services - Core and EPSDT Program Overview for Kentucky Medicaid May 2014. Annual Report #93 EPST CMS-416 was not submitted in 2014, since Anthem began operation in January 2014 and began enrolling children and adolescents in July 2014. Therefore, the MCO did not have data to report for 2014. The first report was submitted in March 2015 as per onsite staff, and preliminary results were provided onsite. The report is to be reviewed by Quality Management Committee.	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:		Full	This requirement is addressed in the Corporate Policy and Procedure EPSDT Services - Core, which describes the CMS requirements for EPSDT providers. The Kentucky-specific requirements (per 907 KAR 1:034 Section and Section 8) are included in the EPSDT Program Overview for Kentucky Medicaid, May 2014 on page 8 under "Provider Information".	

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**
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	Access to EPSDT providers is addressed in the 2014 EPSDT Clinics Program Guide, the EPSDT Program Coordinator position description, and the EPSDT Program Overview for Kentucky Medicaid May 2014. Anthem does not currently track EPSDT providers in GeoAccess reports. Appointment access and availability studies are conducted at the Corporate level and have not yet targeted EPSDT providers. The managed care organization (MCO) does monitor access complaints and grievances and track member receipt of services. **Recommendation for Anthem** The MCO should monitor EPSDT provider access and availability to ensure member access to EPSDT services.	
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [(i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.		Full	This requirement is addressed in the Corporate Policy and Procedure EPSDT Corporate Outreach and Monitoring, under materials and education for new members and mailed preventive health and overdue reminders for current members; Corporate Policy and Procedure EPSDT – Core Policy, pages 3-4, Procedure #2, 3, 4; EPDST Program Overview for Kentucky Medicaid, May 2014 page 5, Program Outreach; and the EPSDT Coordinator position description. Member outreach and education activities are described in quarterly Report #24	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			submitted for Q1 – Q4 2014. Additionally, the MCO submitted a sample Excel file from the EPSDT tracking database.	
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 continued benefits if State Fair Hearing upholds the MCO's decision. 0 of 2 expedited appeal files contained	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.**

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**
			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. **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	

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**
			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. Upon the next review, IPRO will evaluate the Policy and Procedure and complete an appeals file review to ensure same.	
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.		Full	This requirement is addressed in the 2014 EPSDT Program Overview for Kentucky Medicaid and EPSDT Assessment Summary. Provision of EPSDT services cannot be fully assessed since Anthem began operation in January 2014 and began enrolling children and adolescents in July 2014; therefore, the MCO did not have data for annual Report #93 EPST CMS-416 (2014). The first report was submitted in March 2015. The MCO provided evidence of tracking of EPSDT services received as per the Department's periodicity schedule in the Proactive Member List for EPSDT.	
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034. The Primary		Full	This requirement is addressed in the Provider Manual, page 8, Section 2, Provider	

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.			Types, Access and Availability. Monitoring of Primary Care Physician (PCP) provision and documentation of services is addressed in the EPSDT Chart Audit Tool 2014. No results were available for 2014, but audits are in process with the HEDIS reviews currently underway. The MCO provided an Excel spreadsheet entitled Kentucky EPSDT Audit that included a sample of members with services provided and date of service.	
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. **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.	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.

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**
			Anthem should submit the updated Policies and Procedures to DMS. Upon the next review, IPRO will evaluate the Policies and Procedures to ensure same.	
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J.		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 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.	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 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**
			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. **Final Review Determination** No change in review determination. 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. Upon the next review, IPRO will evaluate the Policies and Procedures and the Provider Manual to ensure same.	
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	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 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**
			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. **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. **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. Upon the next review, IPRO will evaluate tracking of EPSDT services to ensure same.	

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**
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.		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 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. **Final Review Determination** No change in review determination. Anthem should ensure that the Case Management Program Description and Policies and Procedures are updated to incorporate these requirements. Anthem should submit the updated Program Description and Policies and	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 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**
			Procedures to DMS. Upon the next review, IPRO will evaluate the Program Description and Policies and Procedures to ensure same.	
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 tracked for each eligible member and the MCO can ensure that each member receives needed services.	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 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**
			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. Upon the next review, IPRO will evaluate the EPSDT record system to ensure same.	
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	This requirement is addressed in the Policy and Procedures Coordination of Care Between Physical and Behavioral Health Providers and Monitoring Coordination of Care – Core Policy.	
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.		Full	This requirement is addressed in the Policy and Procedures Coordination of Care – Core and Corporate EPSDT Services-Core Policy and EPSDT Program Overview for Kentucky Medicaid (referrals to these services).	
K. Participate in any state or federally required chart audit or quality assurance study.		Full	IPRO, the EQRO conducts an EPSDT validation study annually. Anthem is participating in the SFY15 study with a review period in 2014.	

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**
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 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.	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 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**
			Recommendation for Anthem The MCO should develop and present training for assessment procedures for nurse practitioners, nurses and physician assistants who provide EPSDT services. **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. Upon the next review, IPRO will evaluate EPSDT training to ensure same.	
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	Anthem has submitted encounter records to DMS, as required. Anthem began operating in January 2014 and began enrolling children and adolescents in July 2014; therefore, it has not yet been able to submit the annual CMS-416 report. The first report was submitted in March 2015, and preliminary results were provided onsite. Anthem was able to submit the following MCO reports: Report #24 Overview of Activities Related to EPSDT, Pregnant Women, Maternal and Infant Death and Report #38 EPSDT Special Services Report.	

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**
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.		Full	This requirement is addressed in EPSDT Coordinator Responsibilities/position description. The staff member is identified on the sample EPSDT provider cover letter.	
22.1 Required Functions				
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.		Full	This requirement is addressed in Policy and Procedure 2014 EPSDT Program Overview Kentucky Medicaid and the 2014 EPSDT Clinic Days Program Guide which is collaboration with high-volume offices to provide EPSDT services at a specific day/time for Anthem members up to the age of 21. This requirement is also addressed in the EPSDT Coordinator position description.	
37.9 EPSDT Reports				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.		Full	Anthem has submitted encounter records to DMS, as required. Annual report #93 EPST CMS-416 was not found. Since Anthem began operation in January 2014 and began enrolling children and adolescents in July 2014, the MCO did not have data to report in 2014. The first report was submitted in March 2015.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

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	13	3	4	0
Total Points	39	6	4	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		**2.45**		

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

File Review

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

Reports

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

Draft Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in 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	Anthem submitted copies of contracts with the following subcontractors: AIM Diagnostic DentaQuest of Kentucky, LLC Express Scripts, Inc. McKesson Health Solutions, Inc. Physician's Pharmacy Alliance Scion Dental Each contract contained sections detailing the following: delegated activities, reporting responsibilities of the contractor, and sanctions and penalties that may be imposed for underperformance.	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.		Full	Anthem submitted copies of predelegation notice and audit reports for the following subcontractors: AIM Diagnostic DentaQuest of Kentucky, LLC Express Scripts, Inc. McKesson Health Solutions, Inc. Physician's Pharmacy Alliance Scion Dental	

Draft 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**
			Anthem's Vendor Selection and Oversight program (page 4) assigns responsibility to the Delegation Workgroup (DWG) for delegation oversight activities such as pre-delegation evaluations, annual and semi-annual audit analysis and ongoing oversight to include analysis of quarterly reports through the Joint Operation Meetings (JOM).	
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	Anthem's Vendor Selection and Oversight program (page 4) assigns responsibility to the Delegation Workgroup (DWG) for delegation oversight activities such as pre-delegation evaluations, annual and semi-annual audit analysis and ongoing oversight to include analysis of quarterly reports through the Joint Operation Meetings (JOM). The Quality Management Oversight of Delegated Activities Policy and Procedure (page 6) states that corporate auditors are required to perform an annual audit for existing delegates. The audit scope is dependent upon the type of services/functions that are delegated. A desktop and/or an onsite audit are conducted annually by the functional department SME/corporate auditor. The pre-delegation audit must be	

Draft 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**
			completed and approved by VSOC prior to the delegated vendor contract effective date. Audit findings are presented to the Delegation Workgroup Committee per VSOC program requirements" Anthem submitted copies of their annual audit reports for 2014 for the following subcontractors: AIM Diagnostic DentaQuest dba EyeQuest Express Scripts, Inc. McKesson Health Solutions, Inc. Physician's Pharmacy Alliance Scion Dental	
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.		Full	Anthem's Quality Management Oversight of Delegated Activities (page 6) addresses this requirement. Anthem submitted copies of the final audit reports for the following subcontractors: AIM Diagnostic DentaQuest dba EyeQuest Express Scripts, Inc. Physician's Pharmacy Alliance Scion Dental These documents are evidence that Anthem issues Corrective Action Plans (CAPs) when deficiencies are observed	

Draft 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**
			during these audits, and the delegates are given 30 business days to respond. The Express Scripts, Inc. Corrective Action Plan (CAP) Pharmacy Services - Compliance and Audit Policy and Procedure (page 2), which outlines the phases of the WLP/ESI Corrective Action Plan process, states that responses should include the root cause of the issue and barrier analysis and a detailed project plan explaining how the issue will be resolved, including specific milestones/timelines According to the Joint Operations Meeting with Delegates Policy and Procedure, Anthem holds Individual Joint Operation Meetings (JOMs) with all delegates performing core administrative functions on behalf of the Company. The JOMs are held quarterly no later than sixty (60) days after the quarter end, and the agenda includes a discussion of CAPs.	
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	This language is included in the contract with the vendor.	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.		Full	The Quality Management Oversight of Delegated Activities Policy and	

Draft 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**
			Procedure, Health Plan Oversight for Delegate Activities Policy and Procedure and the Vendor Selection and Oversight Program meet this requirement.	
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	The copies of contracts submitted for the following delegates all contain a section addressing subcontractor indemnity: AIM Diagnostic DentaQuest of Kentucky, LLC Express Scripts, Inc. McKesson Health Solutions, Inc. Physician's Pharmacy Alliance Scion Dental	
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	The Kentucky Medicaid Attachment to the delegate agreements and contracts contains this contract language.	
6.2 Requirements				

Draft 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**
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. 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 Subcontract within ten (10) days following termination.		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky specific requirements. Anthem provided email evidence that subcontractor agreements and contracts were reviewed and approved by DMS, specifically for the following subcontractors: AIM Diagnostic DentaQuest dba EyeQuest Express Scripts, Inc. McKesson Health Solutions, Inc. Physician's Pharmacy Alliance Scion Dental	
The Department's subcontract review shall assure that all				

Draft 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**
Subcontracts:				
A. Identify the population covered by the Subcontract;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;		Full	The individual delegate contracts submitted for review meet this requirement.	
C. Specify procedures and criteria for extension, renegotiation, and termination;		Full	The individual delegate contracts submitted for review meet this requirement.	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
G. Contain no provision that provides incentives,		Full	The Kentucky Medicaid Attachment,	

Draft 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**
monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;			which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
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	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
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	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements.	
(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		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and	

Draft Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and information to Members,			Commonwealth regulations.	
(2) all QAPI requirements,		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations.	
(3) all record keeping and reporting requirements,		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations.	
(4) all obligations to maintain the confidentiality of information,		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations.	
(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	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations.	
(6) all indemnification and insurance requirements, and		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific	

Draft 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**
			requirements, and all other federal and Commonwealth regulations.	
(7) all obligations upon termination;		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations.	
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	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations. Anthem submitted copies of their annual audit reports for 2014 for the following subcontractors: AIM Diagnostic DentaQuest dba EyeQuest Express Scripts, Inc. McKesson Health Solutions, Inc. Physician's Pharmacy Alliance Scion Dental	
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	Anthem submitted proof of accreditation for the following subcontractors: AIM Diagnostic – URAC, NCQA DentaQuest dba EyeQuest – NCQA McKesson Health Solutions, Inc. – NCQA, URAC	

Draft 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**
			Scion Dental – URAC In the Final Audit Letter Notice sent to the subcontractors prior to the annual audits, current accreditation certificates (URAC; NCQA) are reviewed as part of the annual audits.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.		Full	Anthem's Quality Management Oversight of Delegated Activities (page 6) states "Audit findings are reviewed for compliance with federal, state, NCQA and AAAHC, as applicable, accreditation requirements. Any areas of non-compliance are addressed with the delegate through a formal corrective action plan." Anthem submitted copies of the final audit reports for the following subcontractors: AIM Diagnostic DentaQuest dba EyeQuest Express Scripts, Inc. Physician's Pharmacy Alliance Scion Dental These documents are evidence that Anthem issues Corrective Action Plans (CAPs) when deficiencies are observed during these audits, and the delegates are given 30 business days to respond.	

Draft 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**
			The Express Scripts, Inc. Corrective Action Plan (CAP) Pharmacy Services - Compliance and Audit POLICY AND PROCEDURE (page 2), which outlines the phases of the WLP/ESI Corrective Action Plan process, states that responses should include: root cause of the issue and barrier analysis and detailed project plan explaining how the issue will be resolved, including specific milestones/timelines. According to the Joint Operations Meeting with Delegates Policy and Procedure (page 4), Anthem holds Individual Joint Operation Meetings (JOMs) with all delegates performing core administrative functions on behalf of the Company. The JOMs are held quarterly no later than sixty (60) days after the quarter end, and the agenda includes a discussion of CAPs.	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that all contracts meet the Kentucky-specific requirements, and all other federal and Commonwealth regulations.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.		Full	The Kentucky Medicaid Attachment, which is appended to the delegate agreements and contracts, ensures that	

Draft 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**
			all contracts meet the Kentucky specific requirements, and all other federal and Commonwealth regulations.	
Section 6.2 requirements would be applicable to Subcontractors characterized as Risk Arrangements. Section 6.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services to Members.		Full	Anthem only submitted evidence of compliance with delegation contract requirements for their non-administrative subcontractors, i.e. • AIM Diagnostic • DentaQuest dba EyeQuest • Express Scripts, Inc. • Physician's Pharmacy Alliance • Scion Dental Anthem's administrative contractors (see list Kentucky Medicaid Vendors.xlsx) are not bound to the same contractual obligations.	
6.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $25,000 or five percent (5%) of the Subcontractor's operating expense.		Non-Compliance	Anthem submitted a 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. **Final Review Determination** No change in compliance level.	Policy has been updated for 2015.

Draft 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**
			The Policy and Procedure is compliant for 2015. No further action is needed.	
6.4 Remedies				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.				

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

Draft Final Findings

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

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	33	0	0	1
Total Points	99	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		**99/34 =2.91**		

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

Draft Final Findings

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

Documents

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

Reports

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

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March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
17.1 Encounter Data Submission				
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Record set in formats and timelines prescribed by the Department as defined in the Contract.		Full	This requirement was addressed through the Claims Workflow document and policy Encounter file Completeness and Accuracy.	
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter.		Full	This is addressed through the HIPAA 837 claims file submission, all claims are given a unique identifier.	
At a minimum, the Contractor shall be required to electronically provide Encounter Record to the Department, on a weekly schedule.		NA	Report #64 did show submissions in 2014 however they were not done weekly. Anthem requested and received an extension to submit weekly encounters until January 2015. This correspondence is documented in the MCO pre onsite folders. Review of MCO Report #64 Encounter Data Summary Report was performed.	
Encounter Record must follow the format, data elements and hod of transmission specified by the Department.		Full	This is addressed by the fact that DMS is receiving HIPAA compliant files from Anthem.	
All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible.				
The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department.		Full	This is addressed in policy Encounter Completeness and Accuracy.	
The electronic test files are subject to Department review				

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and approval before production of data.				
The Contractor shall have the capacity to track and report on all Erred Encounter Records.		Full	The ability to track erred encounter records is addressed in report 0011 Wrap Pends and Rejections. MCO Report #64 Encounter Data Summary Report was reviewed. Includes review of MCO Report #64 Encounter Data Summary Report	
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounter Record in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounter Records as directed by the Department.		Full	This is addressed by means of submitting HIPAA compliant files and the fact that report #64 is showing that files are being accepted by DMS.	
All subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.		Full	This is addressed in language provided in the subcontract agreements.	
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contract person is not available.		Full	The plan provided minutes to the technical work group meetings hosted by DMS with plan contact persons for Anthem.	
17.2 Technical Workgroup				
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter		Full	This is addressed with the Meeting minutes of the Technical Workgroup that were provided showing Anthem attendance.	

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Record.				
18 Kentucky Health Information Exchange (KHIE)				
The Contractor shall make a good faith effort to encourage all Providers in their Network to establish connectivity with the KHIE.		Full	This is addressed in the Medicaid Addendum Prof Legacy102413 – KHIE.	
29.1 Claims Payments				
In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims.		Full	This is addressed with Report 53 for Q1 and Q2 2014 and the Annual Report - 2014 Claim Prompt Pay Report.	
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.		Full	This is addressed with Report 53 for Q1 and Q2 2014 and the Annual Report - 2014 Claim Prompt Pay Report.	

Final Findings

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Quality Assessment and Performance Improvement: Health Information Systems

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	12	0	0	0
Total Points	36	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Health Information Systems
Suggested Evidence

Documents

Policies/procedures for:

- Claims processing
- Claims payment
- Encounter data reporting

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

Reports

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

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MCO: Anthem Blue Cross Blue Shield

Final Findings

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

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
who also require health and related services of a type or amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that 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.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.		Full	Addressed in Anthem Medicaid Case Management Program Description, Staff Roles and Qualifications pages 10-11 and Policy and Procedure GBD-CM-002 Case Manager Role and Functions.	
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.		Full	Includes review of MCO Report #79 HRAs (see Quarterly Desk Audit results) Addressed in Policy and Procedure GBD-CM-	

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
			019 Case Management Program Identification and Anthem Medicaid Case Management Program Description pages 12-18. The 2014 Quarterly Desk Audit results for Report #79 HRA, included the following: Q1 - 62 total HRAs initiated, 0 for pregnant members, 95% (~59) completed in 90 days (non-pregnant), not applicable for % completed in 30 days (pregnant members), 52 members enrolled in Care Management (CM) and 0 members enrolled in Disease Management (DM). No MCO-specific comments were provided. Q2 – 12,463 HRAs initiated, 21 for pregnant members, 14% (~1742) completed within 90 days (non-pregnant), 0% (0) completed within 30 days (pregnant), 247 members enrolled in CM and 1,323 members enrolled in DM. Comments: The data reported in Q2 should be validated by Anthem. The MCO reported 12,463 HRAs initiated and only accounts for approximately 2,700 HRAs as completed, in process, not completed after reasonable efforts or member refused to participate. Q3 – 17,452 HRAs initiated, 170 for pregnant members, 13% (~2247) completed within 90 days (non-pregnant), 0% (0) completed	

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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
			within 30 days (pregnant), 588 members enrolled in CM and 3,590 members enrolled in DM. Comments: The data reported in Q3 should be validated by Anthem. The MCO reported 17,452 HRAs initiated and only accounts for approximately 5,000 HRAs as completed, in process, not completed after reasonable efforts or member refused to participate. In addition, Anthem should define "reasonable efforts" as a footnote to the report, e.g., number of attempts made, methods used (phone, mail, etc.). Q4 – 20,011 HRAs initiated, 292 for pregnant members, 5% (~986) completed within 90 days (non-pregnant), 0% (0) completed within 30 days (pregnant), 889 members enrolled in CM and 2,471 enrolled in DM. Comments: Anthem should define "reasonable efforts" as a footnote to the report, e.g., number of attempts made, methods used (phone, mail, etc.). Anthem should describe efforts to improve the timeliness for completing HRAs for pregnant and non-pregnant members.	
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	Addressed in Policy and Procedure GBD-CM-019 Case Management Program Identification and Anthem Medicaid Case Management Program Description and Policy and Procedure Care Management/	

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**
			Complex Care Management Overview – Kentucky, section "Definitions" page 1, Care Management functions #5 (Coordination of Care) and #9 (Continuity of Care).	
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.		Full	Addressed in Anthem Medicaid Case Management Program Description, "Corporate Oversight of the Case Management Program" page 8 which discusses integration of the CM Program and other functional areas; Quality Management, Reporting and Outcome Measurement on pages 32-33; Program Evaluation on page 37.	
34.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.		Full	Addressed in Anthem Medicaid Case Management Program Description, "Scope of Services" on page 6, which states that services offered through the CM program include "coordination of care with PCP's and specialty providers." .	
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		Full	Addressed in Anthem Medicaid Case Management Program Description,	

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**
Department for approval.			"Corporate Oversight of the Case Management Program" on page 4, which describes the CM Program features including:"Care Coordination with planned interventions, driven by a case management plan that includes; Assisting the member in navigating the healthcare system; Assisting the member with transitions of care; Collaboration with physician(s) and their plan of treatment."	
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.		Full	Addressed in Policy and Procedure GBD-CM-19 Case Management Program, Case Identification, which provides details of the MCO's methods for identifying members with special health care needs that can benefit from CM services. Anthem Medicaid Case Management Program Description, Identification, Screening and Grouping on pages 12-18 addresses the process used to identify members appropriate for CM services; Initial Assessment and Leveling on pages 20-23 addresses the CM assessment process; Case Planning on pages 23-25 addresses the development of care plans and interventions for members in the CM program.	
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by		Full	Includes review results for Care Coordination and Complex Case Management files	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
the Department.			Anthem Medicaid Case Management Program Description, Case Planning, on pages 23-25, addresses the development of care plans and interventions for members in the CM program and in Communication of the Case Management Plan, which addresses coordination of care with the member, any caregivers, the member's PCP and any specialists involved in the member's care. <u>Care Coordination File Review Results</u> 10 files were reviewed. 8 of 8 applicable files were compliant. 1 member was followed by CM during 2014 but opted not to enroll in CM until 2015. 1 member had no CM needs identified. <u>Complex Case Management File Review Results</u> 10 of 10 files were compliant.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.		Full	Includes review results for Care Coordination and Complex Case Management files Addressed in Anthem Medicaid Case Management Program Description, Case Planning, on pages 23-25, which discusses the development of care plans 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**
			interventions for members in the CM program and in Communication of the Case Management Plan, which discusses coordination of care with the member, any caregivers, the member's PCP and any specialists involved in the member's care. Addressed in Policy and Procedure GBD-CM-004 Case Manager Monitoring, Follow-Up and Evaluation which defines the process for assessing progress towards meeting care plan goals, making appropriate changes to the Care Plan (as needed) and progress to overcoming barriers identified in the Care Plan. <u>Care Coordination File Review Results</u> 10 files were reviewed. 8 of 8 applicable files were compliant. 1 member was followed by CM during 2014 but opted not to enroll in CM until 2015. 1 member had no CM needs identified. <u>Complex Case Management File Review Results</u> 10 of 10 files were compliant.	
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		Non-Compliance	Addressed in Policy and Procedure DCBS – Foster Care Children; however, this is a draft policy that was not approved in 2014.	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services.

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.			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. **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. **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 measure utilization, access, complaints and grievances, and satisfaction specific to the DCBS population is completed	Plan – send draft to policy committee for review and approval through policy and procedure committee with revision, review and approval completed in July 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**
			and actions taken where warranted. Upon the next review, IPRO will evaluate Policies and Procedures and implementation of indicators specific to the DCBS population to ensure same.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.		Full	Addressed in the Member Handbook, Case Management and Service Coordination, on pages 29-30. Addressed in the Provider Manual, Section 4.3 Members with Special Needs on pages 39-40, Section 5.5 Case Management Services on pages 44-45, and Section 5.6 Disease Management Centralized Care Unit on pages 45-47.	
35.1 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		Full	Addressed in Anthem Medicaid Case Management Program Description,	

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**
individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.			Identification, Screening and Grouping on pages 12-18.	
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.		Full	Addressed in Anthem Medicaid Case Management Program Description, Identification, Screening and Grouping on pages 12-18. Addressed in Policy and Procedure GBD-CM-19 Case Management Program, Case Identification, which provides details of the MCO's methods for identifying members with special health care needs that can benefit from CM services.	
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.		Full	Addressed in Anthem Medicaid Case Management Program Description, Initial Assessment and Leveling, on pages 20-23, which describes the CM assessment process and the method used by the MCO to stratify members need for CM services based on the acuity level (levels = Low, Medium, High, Severe or Complex/Catastrophic). The staff is appropriate health professionals.	
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		Minimal	Includes review of MCO Report #20 Utilization of Subpopulations and ISHCN (see Quarterly Desk Audit results)	Anthem will add the contract language to the relevant Policies and Procedures. For Report #20, we will report: the total

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**
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 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 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."	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. 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 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
			Addressed in Policy and Procedure Care Management/Complex Care Management, Definition section, "Individuals with Special 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 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	

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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 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. 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	

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
			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. 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	

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
			and the number of 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. **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. Upon the next review and as part of the quarterly desk reviews, IPRO will evaluate the Policies and Procedures and Report #20 to ensure same.	
The Contractor shall develop and distribute to ISHCN		Substantial	The Plan provided copies of the following	Anthem will consider creating educational

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**
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.			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** 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). **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. Upon the next review, IPRO will evaluate the information and materials available and distributed to ISHCN to ensure same.	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 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.
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.		Full	Addressed in Anthem Medicaid Case Management Program Description, Identification, Screening and Grouping on	

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**
			pages 12-18, which describes the process used to identify members appropriate for CM services; Initial Assessment and Leveling on pages 20-23, which describes the CM assessment process; Case Planning on pages 23-25, which describes the development of care plans and interventions for members in the CM program.	
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	Addressed in Anthem Medicaid Case Management Program Description, Case Planning on pages 23-25, which describes the development of care plans and interventions for members in the CM program.	
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	Addressed in the Provider Manual, on pages 21-22, which describes Clinical Practice Guidelines. The specific physical and behavioral clinical practice guidelines can be found on the MCO's website at : https://mediproviders.anthem.com/Documents/KYKY_CAID_ClinicalPracticeGuidelinesMatrix.pdf	
35.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients, foster care children or adopted 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		~~Minimal~~ Substantial	Includes review results for DCBS Service Plans and DCBS Claims/Case Management files	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

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
DCBS 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.			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. ~~3 of 10 files contained a Service Plan.~~ ~~1 of 3 Service Plans contained both an MCO and a DCBS signature.~~ ~~3 of 10 cases demonstrated use of the service plan to identify the member's medical needs and need for CM.~~ 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. <u>DCBS Claims/Care Management File Review Results</u>	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 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.

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**
			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, are ~~signed by an MCO representative and 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. **Final Review Determination** The review determination is changed to substantial based the following:	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 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**
			Submission of Report #65 Full compliance with the file 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. Upon the next review, IPRO will evaluate the Policies and Procedures and conduct a file review of DCBS clients' utilization and care coordination.	
35.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.		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.	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval.

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**
			Final Review Determination No change in review determination. Anthem should ensure that in 2015, the Policy and Procedure is approved.	
35.4 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.		~~Minimal~~ Substantial	Includes review results for DCBS Service Plans files 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. DCBS Service Plan File Review Results 10 files were reviewed. ~~3 of 10 files contained a Service Plan.~~ ~~1 of 3 Service Plans contained both an MCO and a DCBS signature.~~ ~~3 of 10 cases demonstrated use of the service plan to identify the member's medical needs and need for CM.~~ 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	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval.

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**
			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. **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.	
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.		~~Minimal~~ Substantial	Includes review results for DCBS Service Plans files 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. DCBS Service Plan File Review Results 10 files were reviewed.	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval.

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
			~~3 of 10 files contained a Service Plan.~~ ~~1 of 3 Service Plans contained both an MCO and a DCBS signature.~~ ~~3 of 10 cases demonstrated use of the service plan to identify the member's medical needs and need for CM.~~ 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. **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	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Plans, when available, are ~~signed by an MCO representative and are~~ used to determine if the member should be enrolled in case management.	
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.		~~Minimal~~ Substantial	Includes review results for DCBS Service Plans files 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. ~~3 of 10 files contained a Service Plan.~~ ~~1 of 3 Service Plans contained both an MCO and a DCBS signature.~~ ~~3 of 10 cases demonstrated use of the service plan to identify the member's medical needs and need for CM.~~ 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.	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval.

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. **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 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.		~~Minimal~~ Not Applicable	Includes review results for DCBS Service Plans files 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. DCBS Service Plan File Review Results 10 files were reviewed. ~~3 of 10 files contained a Service Plan.~~ ~~1 of 3 Service Plans contained both an MCO and a DCBS signature.~~ ~~3 of 10 cases demonstrated use of the~~	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval.

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
			~~service plan to identify the member's medical needs and need for CM.~~ 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. ~~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, are signed by an MCO representative and are used to determine if the member should be enrolled in case management.~~ **Final Review Determination** The review determination is changed to Not Applicable. However, Anthem should ensure that in 2015, the Policy and Procedure is approved. Anthem should make efforts to obtain Service Plans from DCBS for its enrolled	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			DCBS/Foster and ensure that the Service Plans, when available, are ~~signed by an MCO representative and are~~ used to determine if the member should be enrolled in case management.	
35.5 Children Receiving Adoption Assistance				
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.		Non-Compliance	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. **Recommendation for Anthem** Anthem should ensure that in 2015, the Policy and Procedure is approved. ~~Anthem should make efforts to obtain Service Plans from DCBS for its enrolled Adoption Assistance members and ensure that the Service Plans are signed by an MCO representative and are used to determine if the member should be enrolled in case management.~~ **Final Review Determination** No change in review determination.	Anthem will finalize the draft policy that appropriately addresses Court Ordered Services. Plan – send draft to policy committee for review and approval.

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**
			Anthem should ensure that in 2015, the Policy and Procedure is approved. Anthem should make efforts to obtain Service Plans from DCBS for its enrolled children receiving Adoption Assistance and ensure that the Service Plans, when available, are ~~signed by an MCO representative and are~~ used to determine if the member should be enrolled in case management.	
32. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.		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.""	These areas will be addressed by policy draft, adoption and implementation. Policy drafted in 2015 will be adopted and implemented.

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**
			Draft Policy and Procedure Provider Recruitment and 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. **Final Review Determination** No change in review determination. Anthem should ensure that the Policy is approved and once approved, submitted to DMS. Upon the next review, IPRO will evaluate the Policy to ensure same.	
32.8 Pediatric Interface				
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.				
Preventive and remedial care 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,		Non-Compliance	The MCO did not submit any documentation in support of the requirement. The MCO reported that it is revising the	This policy will be drafted, adopted, and implemented, by the Health plan

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.			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. **Final Review Determination** No change in review determination. Anthem should ensure that the Policy is developed, approved and once approved, submitted to DMS and implemented. Upon the next review, IPRO will evaluate the Policy to ensure same.	
Services provided by HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent care as mandated by the ACA. The Contractor shall		Non-Compliance	The MCO did not submit any documentation in support of the requirement.	Both policies will be drafted, adopted and implemented, by the Health plan

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.			**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. **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. Upon the next review, IPRO will evaluate the Policies to ensure same.	
37.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for		Minimal	Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results)	Anthem will ensure that MCO Reports #65 Foster Care Report and #66 Guardianship Report, both monthly reports, show all

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**
Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.			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 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. **Final Review Determination** No change in review determination. Anthem should ensure that Reports #65 and #66 are updated to include all required information. Upon the quarterly desk reviews and the next annual review, IPRO will evaluate the Reports to ensure same.	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 switched to quarterly reports as of Feb 2015 per DMS communications.

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem Blue Cross Blue Shield

Final Findings

Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	16	5	3	5
Total Points	48	10	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		**2.10**		

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 requirement
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

Monthly/quarterly reports of service plan reviews conducted for DCBS and DAIL clients
Monthly reports of Foster Care cases

File Review

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014– December 31, 2014
MCO: Anthem BlueCross Blue Shield

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.6 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.		Full	This requirement is addressed in Policy and Procedure Member Rights and Responsibilities-KY as well as the Provider Manual, section 3.15 pages 34-37 and Member Handbook, pages 54-58.	
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 provided to any Out-of-Network Provider upon request from the Provider should be added to the	The Provider Manual has been updated for 2015 to include the required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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 Manual. **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. Upon the next review, IPRO will evaluate the Provider Manual to ensure same.	
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
C. Consent for or refusal of treatment and active participation in decision choices;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
F. Timely access to care that does not have any communication or physical access barriers;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
I. Timely referral and access to medically indicated		Full	This requirement is addressed in the	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
specialty care; and			Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.		Full	This requirement is addressed in policy and procedure Member Rights and Responsibilities-KY as well as the Provider Manual, 3.15 and Member Handbook, pages 54-58.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, page 58.	
B. Abide by the Contractor's and Department's policies and procedures;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
C. Become informed about service and treatment options;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
D. Actively participate in personal health and care decisions, practice healthy life styles;		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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 Manual, section 3.15 and Member Handbook, pages 54-58.	
E. Report suspected Fraud and Abuse; and		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, page 59.	
F. Keep appointments or call to cancel.		Full	This requirement is addressed in the Member Rights and Responsibilities-KY policy and procedure as well as the Provider Manual, section 3.15 and Member Handbook, pages 54-58.	
22.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.		Full	This requirement is addressed in the New Member Packet contents document and policy and procedure Member Rights and Responsibilities-KY.	
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	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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 wording was added to the Member Handbook in 2015. **Recommendation for Anthem** The required language should be included in the Member Handbook. **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. Upon the next review, IPRO will evaluate the Member Handbook to ensure same.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.		Full	This requirement is addressed in policy and procedure Member Rights and Responsibilities-KY and the Member Handbook.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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 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	This requirement is addressed in policy and procedure Member Rights and Responsibilities-KY.	
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:		Full	This requirement is addressed in policy and procedure Cultural and Educational Needs.	
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	This requirement is addressed in The Provider Directory, included in the enrollment packet, and at www.anthem.com/kymedicaid	
B. The procedures for selecting a PCP and scheduling an initial health appointment;		Full	This requirement is addressed in the Member Handbook, pages 6 & 11.	
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	This requirement is addressed in the Member Handbook, page 2 and the Welcome Letter.	
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	This requirement is addressed in the Member Handbook, pages 16-27.	
E. Member rights and responsibilities including reporting		Full	This requirement is addressed in the	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
suspected fraud and abuse;			Member Handbook, page 57.	
F. Procedures for obtaining Emergency Care and non-emergency care after hours. For a life-threatening situation, instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 911;		Full	This requirement is addressed in the Member Handbook, pages 31-33.	
G. Procedures for obtaining transportation for both emergency and non-emergency situations;		Full	This requirement is addressed in the Member Handbook, page 4.	
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;		Full	This requirement is addressed in the Member Handbook, page 4.	
I. Procedures for arranging EPSDT for persons under the age of 21 years;		Full	This requirement is addressed in the Member Handbook, page18.	
J. Procedures for obtaining access to Long Term Care Services;		Full	This requirement is addressed in the Member Handbook, page 4.	
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;		Full	This requirement is addressed in the Member Handbook, page 4.	
L. A list of direct access services that may be accessed without the authorization of a PCP;		Full	This requirement is addressed in the Member Handbook, page 30.	
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	This requirement is addressed in the Member Handbook, page 6 and in policy and procedure Member Rights and Responsibilities-KY.	
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	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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. 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. **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. Upon the next review, IPRO will evaluate the Member Handbook to ensure same.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;		Full	This requirement is addressed in the Member Handbook, page 7.	
P. Procedures for obtaining Covered Services from non-network providers;		Full	This requirement is addressed in policy and procedure Out of Area-Out of Network Care	
Q. Procedures for filing a Grievance or Appeal. This shall include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;		Full	This requirement is addressed in the Member Handbook, pages 44-49.	
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;		Full	This requirement is addressed in the Member Handbook, page 3.	
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;		Full	This requirement is addressed in the Member Handbook, pages 4, 12, & 22.	
T. Information on the availability of health education services;		Full	This requirement is addressed in the Member Handbook, page 42.	
U. Information deemed mandatory by the Department; and		Non-compliance	Documentation to address this requirement was not submitted by the MCO. **Final Review Determination** No change in review determination. No documentation was provided and the Member Handbook was not compliant	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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. Upon the next review, IPRO will evaluate the Member Handbook to ensure same.	
V. The availability of care coordination, case management and disease management provided by the Contractor.		Full	This requirement is addressed in the Member Handbook, pages 24, 29 & 40	
30.3 Second Opinions				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.		Full	This is addressed in the Provider Manual, Section 4.6 and Member Handbook, page 7.	
22.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern 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		Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement was addressed in Kentucky EQRO Quarterly Desk Audit Topic: Enrollee Rights and Audit for Anthem. MS contact and staffing addressed in the Member Handbook;	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
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.			Cover Letter, pages 2, 3, 29, & 45 and the Provider Manual, page 3	
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).		Full	This requirement is addressed in the Member Handbook, page 1 and Enrollee Rights Quarterly Desk Audit MCO Report 11.	
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	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the Enrollee Rights Quarterly Desk Audit MCO Report 11.	
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		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	Member Handbook and P&P have been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
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.			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 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. **<u>Recommendation for Anthem</u>**	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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 should add this language to the Member Handbook and provide to members. **<u>Final Review Determination</u>** No change in review determination. 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. Upon the next review, IPRO will evaluate the Member Handbook and the Policy and Procedure to ensure same.	
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	Member Handbook and Provider Manual have been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			requirements. **Recommendation for Anthem** These requirements should be added to the Member Handbook. **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. Upon the next review, IPRO will evaluate the Manual and Handbook to ensure same.	
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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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 should be noted in the Member Handbook that these services are provided by Member Services. **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. Upon the next review, IPRO will evaluate the Handbook, Policy and Manual to ensure same.	
B. 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	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			National Customer Care (NCC). 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. **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. Upon the next review, IPRO will evaluate the Handbook and Policy to ensure same.	
C. Identifying, investigating, and resolving Member Grievances about health care services;		Substantial	Though the Member Handbook and the Provider Manual outline member rights	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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 responsibilities, the documents do not address that Member Services is 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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
D. Assisting Members with filing formal Appeals regarding plan determinations;		Substantial	Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			address that Member Services is responsible for these functions. Policy and procedure Member Services Function meets the requirement but the policy was not updated to include the state of KY until March 2015. **Recommendation for Anthem** It should be noted in the member handbook that these services are provided by Member Services. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;		Substantial	Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;		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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
G. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;		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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			Policy and Procedure Member Services Function meets the requirement but the policy was not updated to include the state of KY until March 2015. **Recommendation for Anthem** It should be noted in the Member Handbook that these services are provided by Member Services. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be		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 Services	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
available for persons who have reading difficulties or visual impairments);			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
l. 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 Services Function meets the requirement but the	Member Handbook submitted contains required language on page 2.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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. **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. Upon the next review, IPRO will evaluate the Handbook, Policy and Manual to ensure same.	
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship,		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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
K. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be		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 Services	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;		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 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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	Member Handbook has been updated with required language.
M. Providing Members with information or referring to		Substantial	Though the Member Handbook and the	Member Handbook has been updated with required

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
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;			Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is 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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	language.
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and		Substantial	Though the Member Handbook and the Provider Manual outline member rights	Member Handbook has been updated with required

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;			and responsibilities, the documents do not address that Member Services is 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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	language.
O. Facilitating access to behavioral health services and pharmaceutical services;		Substantial	Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			address that Member Services is 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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
P. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs		Substantial	Though the Member Handbook and the Provider Manual outline member rights and responsibilities, the documents do not address that Member Services is	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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;			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
Q. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and		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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
refer such problems to the designated Member Services Director for resolution;			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;		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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
S. 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	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.	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			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. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
T. Facilitating access to Member Health Education Programs;		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 Services	Member Handbook submitted contains required language on page 42.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			Function meets the requirement but the policy was not updated to address Kentucky requirements until March 2015. **Recommendation for Anthem** It should be noted in the Member Handbook that these services are provided by Member Services. **Final Review Determination** No change in review determination. It was noted that although the Member Handbook contains the necessary language on page 42, it is dated 01/15. Anthem did not submit the version effective in 2014. Anthem should ensure that materials and documents effective in the review year are submitted for review.	
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in **Covered Services** upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and		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 Services Function meets the requirement but the policy was not updated to address the Kentucky requirements until March 2015. **Recommendation for Anthem**	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			It should be noted in the Member Handbook that these services are provided by Member Services. **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. Upon the next review, IPRO will evaluate the Handbook, Manual and Policy to ensure same.	
V. The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.		Substantial	Policy and Procedure Member Services Function meets the requirement but the policy was not updated to address the Kentucky requirements until March 2015. **Final Review Determination** No change in review determination. The Policy and Procedure did not address this requirement during the review period, CY 2014. Anthem should ensure that the Policy is	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			updated as necessary and submitted to DMS. Upon the next review, IPRO will evaluate the Policy to ensure same.	
30.4 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	This is addressed in the Provider Manual, section 10.12 Billing Members	
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.		Full	This is addressed in the Provider Manual, section 10.13 Client Acknowledgment Statement	
22.9 Choice of Primary Care Provider				

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.		Full	This is addressed in the Member Handbook, page 6, Picking a PCP	
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. **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. Upon the next review, IPRO will evaluate the Policies to ensure same.	P&P has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.		Full	This requirement is addressed the Member Handbook, page 6 and Policy and Procedure Primary Care Provider Selection, Assignment and Change Requests – Kentucky.	
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	Addressed in Policy and procedure PCP Selection Assignment and Change Requests, which allows for change of provider within 30 days, and in the Member Handbook, page 8.	
A member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.		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 their PCP at any time." This is not consistent with the Contract requirement. ~~5.7 Enrollment states that members may change their MCO within the first 90 days, and then once a year thereafter.~~ **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	Member Handbook has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			added to the Member Handbook. **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. Upon the next review, IPRO will evaluate the Handbook and Manual to ensure same.	
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	This requirement is addressed in the Member Handbook, page 8.	
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	This requirement is addressed in the Member Handbook, page 8.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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 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. **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	The Provider Manual and P&P have been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Handbook is dated 01/15. Upon the next review, IPRO will review the Manual, Policies, and documents, as well as the Member Handbook, to ensure same.	
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to Appeal such a transfer in the formal Appeals process. The Provider shall make the change for request in writing. Member may request PCP change in writing, face to face or via telephone.		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 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	The Provider Manual has been updated with required language.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
			meet the requirement. **Recommendation for Anthem** The MCO should add the contract language to the Provider Manual and policies and procedures. **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. Upon the next review, IPRO will review the Manual, Policies, and documents, as well as the Member Handbook, to ensure same.	
30.5 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		Full	The requirement is met in the following documents: Services Outside the Scope of the Covered Services and Referral to a Provider Enrolled in the Medicaid FFS Program, in the Member Handbook, page 27 and the Provider Manual, section 6.2. Also, Policy and Procedure Non-Covered & Cost Effective Alternative Services policy, page 4 section Exceptions: Kentucky and	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
All 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**
changes to the established written referral policies and procedures to the Department for review and approval.			Out of Area - Out of Network policy.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	53	27	3	2
Total Points	159	54	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		**2.54**		

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

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

Reports

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

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MCO: Anthem BlueCross Blue Shield

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**
22.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.		Full	This requirement is addressed in the Community Outreach Plan. The requirement is administered and implemented through Anthem's Outreach Program.	
Creative methods should be used to reach Contractor's Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.		Full	This requirement is addressed in the Community Outreach Plan as well as in the Homeless, Marketing and Outreach Plan materials.	
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.		Full	This requirement is addressed in the Community Outreach Plan. The Community Outreach Schedule includes the frequency and documentation of the activities as well as the staff person(s) responsible.	
22.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.		Full	This requirement is addressed in the Homeless Plan.	
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-		Full	This requirement is addressed in the Homeless Plan.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Face encounters.				
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.		Full	This requirement is addressed in the Member Handbook and in the Homeless Plan.	
22.5 Member Information Materials				
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,		Full	This requirement is addressed in the Member Materials – Appropriateness Policy.	
be published in at least a 14-point font size, and		Full	This requirement is addressed in the Member Materials – Appropriateness Policy.	
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. **Final Review Determination** No change in review determination.	P&P has been updated for 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**
			Anthem should ensure that the Policy and Procedure is updated to meet the Contract requirements and submitted to DMS. Upon the next review, IPRO will evaluate the Policy to ensure same.	
Font size requirements shall not apply to Member Identification Cards.		Full	This requirement is addressed in the Member Materials – Appropriateness Policy.	
Braille and audiotapes shall be available for the partially blind and blind.		Full	This requirement is addressed in the Member Materials – Appropriateness Policy.	
Provisions to review written materials for the illiterate shall be available.		Full	This requirement is addressed in the Member Handbook. Anthem provides audiotape services for its illiterate members.	
Telecommunication devices for the deaf shall be available.		Full	This requirement is addressed in the Member Handbook.	
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.		Full	This requirement is addressed in the Cultural and Educational Needs Policy whereby Anthem provides language translation to all non-English speaking members.	
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.		Full	This requirement is addressed in the Member Communication Policy.	
All written materials provided to Members, including forms used to notify Members of Contractor actions and decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.		Full	This requirement is addressed in the Member Materials – Appropriateness Policy.	

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**
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 Developmental Health for approval prior to publication and distribution to Members.		Not Applicable	As per the State, DMS has instructed Anthem to submit materials to DMS and the State will submit to DBHDID as needed.	
28.12 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.		Full	This requirement is addressed in the Member Materials – Appropriateness Policy as well as in the Member Handbook.	
The Contractor shall communicate such policies to Subcontractors.		Full	This requirement is addressed in the Provider Manual on page 27.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	17	0	0	1
Total Points	51	0	0	0

Overall Compliance Determination:

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

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: 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

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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**
38.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.		Full	Addressed in the Provider Manual, Section 2.1 Responsibilities of the Primary Care Provider, page 9, "Maintain Medical Records" and Section 3.13 Record Standards, Member Medical Records, pages 31-33.	
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	Addressed in the Provider Manual, Section 2.1 Responsibilities of the Primary Care Provider, page 9. The document states that the provider will: treat member's disclosures and records confidentially, giving members the opportunity to approve or refuse their release; maintain the confidentiality of family planning information and records for each individual member, including those of minor members; comply with all applicable federal and state laws regarding the confidentiality of patient records; share records subject to applicable confidentiality and HIPAA requirements.	.

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall 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. **Final Review Determination** The final review determination is Non-Compliance. Anthem should develop and implement a Policy and Procedure for conducting HIPAA privacy and security audits of provider sites as prescribed by the Department. Upon the next review, IPRO will evaluate the Policy and implementation to ensure same.	
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	Provider Agreement Template section 3.4 "Plan Access To and Requests for Provider Records" addresses the auditing portion of the requirement. Medicaid Participation Attachment to the Anthem Blue Cross Blue Shield Medicaid Provider Agreement, section 2.26 Record Transfer page 8, meets the 10 day requirement and the signed release by the member, which meets the requirement.	
The Contractor shall have a process to		Minimal	The MCO did not submit any documentation	A Medical Record Review policy has been

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.			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."	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 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**
			Recommendation for Anthem The MCO should develop a policy and procedure that details the process for verifying provider compliance with medical record standards. **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. Upon the next review, IPRO will evaluate the Policy and implementation to ensure same.	
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	The MCO did not submit any 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.	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 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**
			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 process for verifying provider compliance with medical record standards. **Final Review Determination** No change in review determination.	

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 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. Anthem should ensure that the process applies to PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services and is conducted not less than every three (3) years. Upon the next review, IPRO will evaluate the Policy and implementation to ensure same.	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;		Minimal	The MCO did not submit any 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.	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.

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Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			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 process for verifying provider compliance with medical record standards. **Final Review Determination** No change in review determination.	

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**
			There was no process in place and reviews were not conducted in CY 2014. Anthem should ensure that a Policy and Procedure for review of provider compliance with preventive and clinical practice guidelines is developed, approved, submitted to DMS and implemented, that improvement actions are taken, and effectiveness is evaluated. Upon the next review, IPRO will evaluate the Policy and implementation to ensure same.	
B. Allow for the tracking and trending of individual and plan wide provider performance over time;		Minimal	The MCO did not submit any 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	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 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
			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 process for verifying provider compliance with medical record standards. **Final Review Determination** No change in review determination. There was no process in place and reviews were not conducted in CY 2014. Anthem should ensure that a process for tracking and trending of individual and plan wide performance for compliance with preventive and clinical practice guidelines is developed, approved, submitted to DMS	

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 implemented, that improvement actions are taken, and effectiveness is evaluated. Upon the next review, IPRO will evaluate the Policy and implementation to ensure same.	
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and		Minimal	The MCO did not submit any 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.	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 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
			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 process for verifying provider compliance with medical record standards. **Final Review Determination** No change in review determination. There was no process in place and reviews were not conducted in CY 2014. Anthem should ensure that the record review process includes a mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns, and the process is approved, submitted to DMS and implemented. Upon the next review, IPRO will evaluate the process and implementation to ensure same.	

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**
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.		Minimal	The MCO did not submit any 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."	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 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**
			Recommendation for Anthem The MCO should develop a policy and procedure that details the process for verifying provider compliance with medical record standards. **Final Review Determination** No change in review determination. There was no process in place and reviews were not conducted in CY 2014. Anthem should ensure that the record review process includes a mechanism for detecting instances of over-utilization, under-utilization, and miss utilization, and the process is approved, submitted to DMS and implemented. Upon the next review, IPRO will evaluate the process and implementation to ensure same	
27.7 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		Full	Addressed in the Provider Manual, section 3.13 Record Standards: Member Medical Records pages 31-33.	

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**
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.				
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	The Provider Manual page 32 and Member Handbook page 54 address that the member is entitled to receive a one free copy of their medical record. Medicaid Participation Attachment to the Anthem Blue Cross Blue Shield Medicaid Provider Agreement, Section 2.25 Records, page 8, meets the requirement to maintain records for 5 years unless federal requirements mandate a longer retention period.	
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		Full	Addressed in the Provider Manual, Section 3.13 Record Standards, Member Medical Records pages 31-33.	

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**
continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:				
A. Member/patient identification information, on each page;		Full	Addressed in the Provider Manual, Section 3.13 Record Standards, Member Medical Records page 32.	
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;		Substantial	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 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. **Final Review Determination** No change in review determination. Anthem should ensure that the	Provider Manual, section 3.13 was updated to address.

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**
			requirements are addressed in the updated Provider Manual and that it is submitted to DMS. Upon the next review, IPRO will evaluate the Manual to ensure same. Anthem should ensure that the requirements are addressed in the updated Provider Manual and that it is submitted to DMS. Upon the next review, IPRO will evaluate the Manual to ensure same.	
C. Date of data entry and date of encounter;		Full	Addressed in the Provider Manual, Section 3.13 Record Standards, Member Medical Records, page 32.	
D. Provider identification by name;		Full	Addressed in the Provider Manual, Section 3.13 Record Standards, Member Medical Records, page 32.	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;		Full	Addressed in the Provider Manual, Section 3.13 Record Standards, Member Medical Records, page 32.	
F. Past medical history, including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);		Substantial	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 history includes prenatal care and birth information,	Provider Manual, section 3.13 was updated to address.

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**
			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. **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. Upon the next review, IPRO will evaluate the Manual to ensure same.	
G. Identification of current problems;		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the requirement.	
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the 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**
indicating review;				
I. Documentation of immunizations pursuant to 902 KAR 2:060;		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the requirement.	
J. Identification and history of nicotine, alcohol use or substance abuse;		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the requirement.	
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;		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. **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. Upon the next review, IPRO will evaluate the Manual to ensure same.	Provider Manual, section 3.13 was updated to address.
L. Follow-up visits provided secondary to reports of emergency room care;		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the requirement.	
M. Hospital discharge summaries;		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the 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**
N. Advanced Medical Directives, for adults;		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the requirement.	
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. **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. Upon the next review, IPRO will evaluate the Manual to ensure same.	Provider Manual, section 3.13 was updated to address.
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	Provider Manual, section 3.13 Record Standards: Member Medical Records page 32 meets the requirement.	
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		Full	Provider Manual, section 3.13 Record Standards: Member Medical Records (Documentation Standards for an Episode of	

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**
conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;			Care) pages 32-33 meet the requirement.	
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	Provider Manual, section 3.13 Record Standards: Member Medical Records (Documentation Standards for an Episode of Care) pages 32-33 meet the requirement.	
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. **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. Upon the next review, IPRO will evaluate the Manual to ensure same.	Provider Manual, section 3.14 was updated to address.
27.8 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and		Full	Policy and Procedure Advanced Directives, Member Handbook "Making A Living Will" (Advance Directives) page 44 and Provider	

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**
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.			Handbook 5.3 Advance Directives pages 43-44 meet the requirement.	
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	Policy and Procedure Advanced Directives, Member Handbook "Making A Living Will" (Advance Directives) page 44 and Provider Handbook 5.3 Advance Directives pages 43-44 meet the requirement.	
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.		Full	Provider Handbook 5.3 Advance Directives pages 43-44 meets the requirement.	
38.2 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		Full	Provider Agreement Template, Article III Confidentiality/Records page 8, Provider Manual, 3.10 Health Insurance Portability and Accountability Act pages 29-30 and	

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**
unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.15.			Member Handbook, HIPAA Notice of Privacy Practices page 60 – all meet the requirement.	
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 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.	Provider Manual, section 3.10 was updated to address.

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
			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. **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. Upon the next review, IPRO will evaluate the Manual to ensure same.	
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.		Full	Provider Agreement Template, Article III Confidentiality/Records page 8 meets the requirement.	.
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		Full	The requirement is met in Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Provider Agreement, section 2.27 Availability of Records page 8.	

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**
duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.				
40.15 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 is the Contractor.		Full	Provider Agreement Template, Article III Confidentiality/Records page 8, Provider Manual, 3.10 Health Insurance Portability and Accountability Act pages 29-30 and Member Handbook, HIPAA Notice of Privacy Practices page 60 – all meet the requirement.	

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

Final Findings

Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	27	2	7	4
Total Points	81	4	7	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.30**		

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

Reviewer Decision:

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

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

Final Findings

Medical Records

Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

Provider compliance assessment/monitoring results and follow-up

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

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**
33.3 General Behavioral Health Requirements				
The Department requires the Contractor's provision of behavioral health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.		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	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 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**
			recovery and resiliency focused behavioral health services in existing policy/procedure or specific behavioral health program description or general policy. **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. Upon the next review, IPRO will evaluate the Policy/Program Description to ensure same.	
33.4 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.		Full	This requirement is addressed in the 2014 Kentucky UM Program description. Access to Behavioral Health Care details timeliness of access to BH services and monitoring of access through site visits and practice-specific satisfaction surveys. Assuring the provision of medically necessary behavioral health services is addressed in the QM Program Description. The Behavioral Health Access and Availability-KY provides "psychiatry provider" Provider: Member	

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**
			ratio (1:900), geographic access /travel times for BH hospitals and BH appointment standards. Providing all medically necessary behavioral health services is addressed in the Provider Manual as an objective.	
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-V classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-V.		Full	This requirement is addressed in the UM Program Description and the Provider Manual. Members can access behavioral health services directly. Access to Behavioral Health Care details standards for timeliness of access to behavioral health services and outlines processes the MCO uses to ensure timely access, including site visits. Anthem reported behavioral health access and network progress in MCO Report #13 Access and Delivery Network Narrative, which notes completed contracting with all fourteen community mental health centers and other providers. No provider or member behavioral health access grievances were reported, and GeoAccess reports for Quarter 4, 2015 include 100% compliance with standards for behavioral health providers. The MCO's use of DSM-V criteria is documented in the UM Program Description, and the Provider Manual	

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**
			addresses this requirement on page 16. The Provider Manual indicates that medical records must record an assessment including multi-axial diagnosis using the most current DSM.	
Providers shall document DSM-V diagnosis and assessment/outcome information in the Member's medical record.		Full	This requirement is addressed in the Provider Manual section that outlines medical record standards. The MCO will assess this documentation in medical record audits planned for 2015 as per onsite staff.	
33.5 Behavioral Health Provider Network				
The Contractor must emphasize access to services, utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.		Full	This requirement is addressed in the 2014 Kentucky UM Program Description. The MCO ensures authorized services are provided by monitoring behavioral health outcomes (MCO Report #118); monitoring claims, complaints and grievances and appeals; and case management.	
The Contractor shall utilize ICD-9/10 coding and DSM-V classification for Behavioral Health billings.		Substantial	The requirement for ICD-9 coding is addressed in Provider Agreements (2 KY IPA EPA Base Medicaid rev 8.1.14 2; KY EFA Version. Medicaid rev 8.1.14 and Addendum for EFA). The use of DSM-V is addressed in the Provider Manual and 2014 Kentucky UM Program Description.	Anthem will include reference to ICD-10 and DSM-V in relation to diagnoses for behavioral health billings in documents when ICD-10 fully implemented in October 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**
			ICD-10 is not addressed in the documents, and DSM-V is not addressed in relation to billing. **Recommendation for Anthem** The MCO should include reference to ICD-10 and DSM-V in relation to diagnoses for behavioral health billings in documents. **Final Review Determination** No change in review determination. Anthem should ensure that the Provider Manual, Provider Agreement(s) and the UM Program Description address all requirements. Upon the next review, IPRO will evaluate the Manual, Description, and Agreements to ensure same.	
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers. Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network. Other eligible providers of behavioral health services include Licensed Professional Clinical Counselor and/or Group, Licensed Marriage and Family Therapist and/or Group, Licensed Psychological Practitioner and/or Group, Behavioral Health Multi-Specialty Group, Licensed Clinical		Full	This requirement is addressed in the Behavioral health Provider Active List, which documents behavioral health providers by type. Behavioral Health Provider 04.16.14 shows "Active" providers as follows: Licensed Professional Clinical Counselor (260); Licensed Marriage and Family Therapist /Licensed Clinical Social Worker (reported in combination, 476);	

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**
Social Worker, Licensed Psychologist and/or Group, Certified Peer and Parental Support Providers.			Therapist (97); and Licensed Psychologist/ Behavioral Health Multi-Specialty Group (183). MCO Report #13 for December 2013 indicates that the MCO has contracted with all community mental health centers in their regions. Geo Access Network Quarterly shows 100% of Urban and Rural members have access to one BH provider within 60 miles.	
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. **Recommendation for Anthem** The MCO should address the provision of behavioral health services by FQHCs and RHCs in policy/procedure. **Final Review Determination** NO change in review determination. Anthem should ensure that the Policy	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 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**
			addresses all requirements, is approved, and is submitted to DMS. Upon the next review, IPRO will evaluate the Policy to ensure same.	
The Contractor shall ensure accessibility and availability of qualified providers to all Members. In order to ensure such accessibility, the Contractor shall, prior to March 1, 2014, submit credentialing documents for no fewer than one hundred and fifty (150) behavioral health providers distributed throughout the state.		Full	This requirement is addressed in the submitted Behavioral Health Provider List and response to corrective action plan dated March 26, 2014. This requirement is also addressed in the Geo Access network quarterly report. The Provider Manual pages 71-72 detail credentialing standards by BH provider type.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.		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	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.

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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**
			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 Handbook and educate members regarding direct access to behavioral health 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. Upon the next review, IPRO will evaluate the Member Handbook and the process to ensure same.	
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health		Full	This requirement is addressed in the Behavioral Health Telephonic Intake	

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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**
individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.			Protocol for Members.	
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the state except for Region 3.		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 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	Anthem will 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.

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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**
			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 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	

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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**
			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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health		Substantial	The 2014 Kentucky UM Program Description indicates that trained personnel staff the behavioral health	Anthem will specify qualifications of behavioral health services professionals staffing the crisis hotline or who are

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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**
emergencies.			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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	accessible to crisis hotline staff to provide assessment, triage and intervention for behavioral health emergencies.
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.		Minimal	This requirement is addressed in the Behavioral Health Telephonic Intake Protocol. The Behavioral Health Telephonic Intake Protocol addresses arranging for immediate face-to-face	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.

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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
			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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	
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	Anthem will ensure that all policies, procedures and manuals consistently reflect the requirement that intake lines are not answered by answering machines.

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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**
			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. **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.	

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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**
			Upon the next review, IPRO will evaluate hotline documentation to ensure same.	
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:		Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) See subcomponents below.	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;		Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) 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. **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.	Anthem will include this requirement for behavioral health hotline calls in policy/procedure.

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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**
			Upon the next review, IPRO will evaluate hotline documentation to ensure same.	
B. No incoming calls receive a busy signal;		Substantial	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) 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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	Anthem will include this requirement for behavioral health hotline calls in policy/procedure.
C. At least eighty percent (80%) of calls must be answered		Substantial	Includes review of MCO Report #11 Call	Anthem will include this requirement for

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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**
by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;			Center (see Quarterly Desk Audit results) 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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	behavioral health hotline calls in policy/procedure.
D. The call abandonment rate is seven percent (7%) or less;		Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in MCO	

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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**
			Report #11 Call Center. In every month of 2014, the call abandonment rate was 0% except for April (5%) and June (1%). Telephonic Access Guidelines includes a standard of a call abandonment rate of <5%.	
E. The average hold time is two (2) minutes or less; and		Non-Compliance	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) 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. **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 reported. Upon the next review, IPRO will	Anthem will monitor the average hold time statistic for hotline calls and include specific requirements for behavioral health hotline calls in policy/procedure.

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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**
			evaluate hotline documentation to ensure same.	
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	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.

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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
			specified. Immediate connection to Suicide Hotline 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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.		Full	The hotline described in the Member Handbook, 2014 Kentucky UM Program Description and Behavioral Health Telephonic Intake Protocol for Members handles emergency and crisis calls 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**
			routine member calls.	
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.		Substantial	MCO Report #11 Call Center 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. **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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	Anthem will include this requirement in policy/procedure.
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all		Minimal	Corporate Policy Cultural Competency addresses cultural competency	Anthem will include cultural competency and interpretation services in behavioral

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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**
Members, including the interpretive services required for effective communication.			responsibilities and training in general for MCO associates. Interpreter services in general are addressed in Access and Availability-Kenctucky. Cultural competency and linguistic access are not addressed specifically with regard to hotline services. **Recommendation for Anthem** The MCO should 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. Upon the next review, IPRO will evaluate hotline documentation to ensure same.	health hotline policy/procedure.
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.		Full	Anthem has a centralized Behavioral Health Call Center to serve multiple markets and can search for appropriate providers. As per onsite staff, call center staff will coordinate with Kentucky specific case management if not specifically knowledgeable about a	

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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**
			provider network in a specific Kentucky service area as needed. This is reflected in the Behavioral Health Telephonic Intake Protocol for Members.	
The Contractor shall conduct on-going quality assurance to ensure these standards are met.		Full	This requirement is addressed in the MCO Report #11 Call Center monitoring of call statistics for behavioral health member calls and after hours calls. Quality monitoring of behavioral health Call Center associates is addressed in Behavioral Health Call Center Department Guidelines.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.		Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) The MCO submitted MCO Report #11 Call Center as noted above.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.			Not applicable.	
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and		Substantial	This requirement is addressed in the Provider Manual and the provider contract document Medicaid Participation Addendum to the Blue	Anthem will proceed with working with DBHDID to introduce the SBIRT in PCP settings to facilitate substance abuse screening by PCPs.

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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**
disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such 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.			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. **Final Review Determination** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH screening by PCPs are fully addressed. Upon the next review, IPRO will evaluate PCP screening documentation to ensure same.	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.
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		Full	This requirement is addressed in the Provider Manual. Behavioral health guidelines and tools are posted on 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**
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.			MCO's provider website. The MCO submitted a PowerPoint presentation delivered to PCPs on 9/23/14 that addresses training for screening for behavioral health conditions in primary care, as well as appropriate treatment and referral to behavioral health specialists (AKYPEC-0425-14 Screen ID of BH Condtns in PriCare Web Invite-KY_FINAL and BH-PC AG Presentation 9-23-14). The MCO also provided an attendance list of PCPs attending this presentation.	
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	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 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	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.

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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
			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 behavioral health needs have coordinated care among providers including PCPs. **Final Review Determination** No change in review determination. Anthem should ensure that the Kentucky-specific requirements coordination of BH and PH care are implemented.	

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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**
			Upon the next review, IPRO will conduct a file review to ensure same.	
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 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.	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.

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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 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. Anthem should ensure that the Kentucky-specific requirements are fully addressed. Upon the next review, IPRO will evaluate the Policy and Procedure and Provider Manual to ensure same.	
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.		Full	This requirement is addressed in the Provider Manual page 21.	
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.		Full	This requirement is addressed in the Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Provider Agreement.	

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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. **Final Review Determination** No change in review determination. Anthem should ensure that the	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.

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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**
			Kentucky-specific requirements for BH are fully addressed. Upon the next review, IPRO will evaluate the Provider Manual, UM Program Description, and Provider Agreement to ensure same.	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.		Full	This requirement is addressed in the Provider Manual and in the Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Provider Agreement.	
33.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.		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. **Final Review Determination** No change in review determination.	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 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**
			Anthem should ensure that the Kentucky-specific requirements for BH are fully addressed. Upon the next review, IPRO will evaluate the Policy to ensure same.	
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.		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. **Final Review Determination** No change in review determination. Anthem should ensure that the Kentucky-specific requirements for BH are fully addressed. Upon the next review, IPRO will evaluate the Policy to ensure same.	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.
33.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
The Contractor shall coordinate with providers of behavioral health services, and state operated or state		Full	This requirement is addressed in the 2014 Kentucky UM Program Description	

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**
contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members admitted to the state psychiatric hospital.			and the Provider Manual. Behavioral Health - Hospital Discharge Coordination Process for Pharmacy addresses discharge planning related to pharmacy. The requirement relevant to Commonwealth operated or contracted facilities is addressed in the Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Facility Agreement. As per onsite staff, quarterly meetings are held with state facilities, and the MCO provided November 2014 Regional Transition Committee Minutes for review.	
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.		Full	This requirement is addressed in the Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid Facility Agreement, and the MCO provided executed state hospital contracts for review. This requirement is also addressed in the Provider Manual.	
In addition, the Contractor's Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.		Full	As per onsite staff, quarterly Continuity of Care meetings are attended by providers, and the MCO sends out reminders to attend to Community Mental Health Centers. The MCO provided November 2014 Regional Transition Committee Minutes for review.	
The Contractor shall ensure the Behavioral Health Service		Full	This requirement is addressed in the	

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 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 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.			Provider Manual. Behavioral Health - Hospital Discharge Coordination Process for Pharmacy addresses the case manager's role with regard to pharmacy after mental health facility discharge.	
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.		Full	This requirement is addressed in the Provider Manual.	
Appropriate follow up by the Behavioral Health Service provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.		Substantial	Addressed in the Provider Manual and Medicaid Participation Attachment to the Anthem Blue Cross and Blue Shield Medicaid 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	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.

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**
			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. **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. Upon the next review, IPRO will evaluate the Provider Manual, contract, HEDIS rates and actions taken for improvement to ensure same.	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.
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.		Full	This requirement is addressed in the Provider Manual page 18.	

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**
33.11 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	This requirement is addressed in the 2014 Kentucky UM Program Description, the Behavioral Health Telephonic Intake Protocol for Members and Access to Behavioral Health Care. This requirement is also addressed in the Provider Manual.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;		Full	Monitoring and prescribing of psychotropic medication are addressed in the Provider Manual and Coordination of Care Between Physical Health and Behavioral Health Providers and Behavioral Health-Hospital Discharge Coordination Process for Pharmacy. The MCO submitted a Medicaid Provider Bulletin that describes a feature of the secure provider website that allows providers to access member information regarding pharmacy prescriptions, prescriber and quantity. The MCO is also conducting a performance improvement project of Antipsychotics in Children and Adolescents.	

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**
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;		Minimal	Policy and Procedure, Monitoring Continuity of Care-Core Processes, indicates that 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. **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. Upon the next review, IPRO will evaluate the monitoring processes and results ensure same.	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.
D. Protect the confidentiality of Member information and records; and		Full	This requirement is addressed in Member Privacy Rights. The Anthem Blue Cross and Blue Shield Medicaid Provider Agreement addresses maintaining member confidentiality. Access to Behavioral Health Care	

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**
			addresses member confidentiality related to outpatient audit.	
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.		Full	This requirement is addressed in the Quality Management Program Description.	
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross Blue Shield

Final Findings

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	26	16	5	3
Total Points	78	32	5	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.30**		

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

Reviewer Decision:

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

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

Final Findings

Behavioral Health Services

Suggested Evidence

Documents

Policies/procedures for:

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

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

Final Findings

Reports

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

File Review

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

KY EQRO ANNUAL REVIEW
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

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**
31.1 Pharmacy Requirements				
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;		Full	The following documents 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.	
B. Retrospective utilization review services;		Full	The following documents satisfy this requirement: A02 Drug Use Evaluation, WellPoint Pharmacy Services Program Description Medicaid 2014.	
C. Formulary and non-formulary services, including prior authorization services;		Full	The following documents satisfy this requirement: A03 Formulary System, A08 Prior Authorization, A40 Step Therapy, A43 Pharmacy and Therapeutics Advisory Committee Kentucky, A45 Pharmacy Benefits Transition of Care/Continuity of Care, Anthem/Blue Cross Blue Shield Preferred Drug List (KYKY_Caid_PDL), KY 2014 PA-required DRUG LIST, WellPoint Pharmacy Services Program Description Medicaid 2014.	

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**
			Includes review of MCO Reports #39 Monthly Formulary Management, #59 Prior Authorizations, and #45b Top 50 Non-PDL Drugs by Cost (see Quarterly Desk Audit results).	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere;		Full	The following documents satisfy this requirement: A05 Pharmacy After Hours Calls, A15 Provider Access and Use of Pharmacy Program, WellPoint Pharmacy Services Program Description Medicaid 2014, Express Scripts - Customer Service Hours of Availability_CQA9015.27.	
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors; and		Full	The following documents satisfy this requirement: WellPoint Pharmacy Services Program Description Medicaid 2014, ESI Network Provider Manual 2014.	
F. Coverage for all drugs for which a federal rebate is available and has been provided by DMS.		Full	The following documents satisfy this requirement: Reject Logic for Non CMS Rebatable Drugs Medicaid-CLA-10, NCPDP Reference Guide to Rebate Processing, Validation, and Dispute Resolution.	
31.2 Formulary and Non-Formulary Services				
The Contractor shall maintain a preferred drug list and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.		Full	The following documents satisfy this requirement: Anthem/Blue Cross Blue Shield Preferred Drug List (KYKY_Caid_PDL), WellPoint Pharmacy Services Program Description Medicaid 2014, A32 Provider Communications of Medicaid Formulary Changes. Websites: https://mss.anthem.com/KY/Pages/pharmacybenefits.aspx https://mediproviders.anthem.com/ky/pages/pharmacy.aspx	
The Contractor shall utilize a Pharmacy and		Substantial	The following documents partially satisfy this requirement: A43 Pharmacy and Therapeutics Advisory Committee Kentucky, Wellpoint Medicaid Value	Anthem will ensure meeting minutes are maintained and can be produced going

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**
Therapeutics Committee (P&T Committee). The committee shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the 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.			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 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 delineating the meeting notification process. **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. Upon the next review, IPRO will evaluate P&T Committee documentation to ensure same.	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.
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members via		Full	The following documents satisfy this requirement: Anthem/Blue Cross Blue Shield Preferred Drug List (KYKY_Caid_PDL), WellPoint Pharmacy Services Program Description Medicaid 2014, A32 Provider Communications of Medicaid Formulary Changes. Websites: https://mss.anthem.com/KY/Pages/pharmacybenefits.aspx https://mediproviders.anthem.com/ky/pages/pharmacy.aspx	

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Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
posting on the web and other relevant means of communication. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.				
31.3 Pharmacy Claims Administration				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system, including voids and full or partial adjustments. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. The Contractor shall be responsible for processing components required for paper Claims.		Substantial	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 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. **Final Review Determination** No change in review determination. Anthem should ensure that a Policy for processing of paper pharmacy claims is developed,	Anthem will implement the PBM policy and procedure for the processing of paper 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**
			approved, submitted to DMS, and implemented. Upon the next review, IPRO will evaluate documentation related to pharmacy claims to ensure same.	
The Contractor maintains, through an online system, appropriate accounts receivable (A/R) records for the Commonwealth to systematically track adjustments, recoupments, manual payments and other required identifying A/R and Claim information.		Substantial	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 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. **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. Upon the next review, IPRO will evaluate documentation related to pharmacy claims to ensure same.	Anthem will implement the PBM policy and procedure for the processing of paper claims.
The Contractor shall interface with the		Full	The following documents satisfy this requirement: A02 Drug Use Evaluation, WellPoint Pharmacy Services Program Description Medicaid 2014,	

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**
Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.			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.	
31.4 Pharmacy Rebate Administration				
The Patient and Affordable Care Act (PPACA) signed into law in March 2010 require states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information including J-code conversions consistent with CMS requirements. The Department will provide this Claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is		Full	The following documents satisfy this requirement: Reject Logic for Non CMS Rebatable Drugs Medicaid-CLA-10, NCPDP Reference Guide to Rebate Processing, Validation, and Dispute Resolution.	

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**
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.				
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.		Full	The following documents 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. Includes review of the following MCO 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	

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**
			#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
March 2015
Period of Review: January 1, 2014 – December 31, 2014
MCO: Anthem BlueCross BlueShield

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	3	0	0
Total Points	33	6	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.79**		

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

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

Reports

Pharmacy reports