KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program			Includes review of MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	
The Contractor shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members.	Full - This requirement is addressed in the Kentucky Anthem Blue Cross & Blue Shield Medicaid 2015 Quality Management Program Description (2016 QM PD), on pages 4-7.			
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.	Full - This requirement is addressed in the Kentucky Anthem Blue Cross & Blue Shield Medicaid 2015 Quality Management Program Description (2016 QM PD), on pages 4-7.			
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.	Full - This requirement is addressed in the Kentucky Anthem Blue Cross & Blue Shield Medicaid 2015 Quality Management Program Description (2016 QM PD), on pages 9-12.			
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.	Full - Quality Improvement Committee Meeting minutes demonstrate linkage regarding data findings from HEDIS performance measures and CAHPS. Quality Member Access Committee Meeting minutes of monthly meetings demonstrate linkage by addressing Grievance/complaints, disenrollment, appeals, quality policies, annual member satisfaction survey, member education material, network access, DentaQuest/Eyequest, community outreach, value added benefits, behavioral health benefits and case management. Quality Management Complaints team meeting minutes were provided, and documented initiating attempts to address grievance issues, e.g., disenrollment pertinent to accessing			

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	suboxone providers, out-of-area provider billing for emergency services, member lack of receipt of EOB. Pages 12 and 20 of Report 84 (QI Program Description) indicates that a Work Plan "may be initiated as a result of findings or reprioritization of projects" and that state reporting requirements will be tracked in the QM Work Plan, with supporting evidence of implementation found in the Anthem KY 2016 Work Plan. In addition, the 2016 Anthem KY Program Evaluation Report 85 documented actions taken in 2016 to address barriers identified, e.g., BH/PH interdisciplinary rounds with Medical Director, and UM staff training to ask about discharge needs beginning at admission, CM outreach to members with dental ED visits to provide with information on area dentists. The Evaluation Report also documented actions taken to address barriers to primary care follow-up after NICU discharge, to outpatient primary care follow-up after discharge for pneumonia, to reduce avoidable ER visits, and to facilitate transition from pediatric to adult care. Improvement opportunities were also identified (e.g., avert intake errors of medical necessity appeals, need to improve access to dental network specialists, and outreach to members with no encounter data to determine unknown barriers to access). On site, the MCO addressed how QI topics are addressed and linked across QI efforts by discussion how the low Cervical Cancer Screening HEDIS rate was brought to the QMC meeting and a PIP developed. Member education was included in a newsletter, with targeted member outreach conducted for members with care gaps. To address members on the Do Not Call List, Care Managers communicated with providers and discovered that PCPs were			

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	conducting PAP tests. The MCO checked geo access and disenrollment reports and complaints for indicators of GYN access barriers, but none were found.			
The QAPI program shall be developed in collaboration with input from Members.	Full - Evidence in support of this requirement was found in the policy entitled, "Quality and Member Advisory Committee." Member sign-in sheets show member attendance for 3 of the 8 QMAC regional meetings, with Region 5 having the most members (6) and Regions 1 and 3 having 1 and 2, respectively. The MCO also provided a sample invitation and member mailing labels in support of implementation of this requirement. Of note, the MCO explained that, although Region 5 showed substantial member participation, participants were comprised of children in foster care whose advocates suggested that participation was required. The MCO addressed this and will brainstorm other means to encourage member participation without implying attendance as a requirement.			
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.	Full - The MCO provided QMAC minutes regarding review of PIP findings.			
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance (NCQA) accreditation for its Medicaid product line.	Full - NCQA Health Plan Accreditation First Survey scheduled for submission on February 7, 2017. Anthem submitted evidence of preparation for NCQA accreditation, including the 2016 NCQA Standards Readiness Tool Kentucky, and an email from NCQA to Anthem regarding an introductory call, as well as additional supporting evidence in the KY 2016 Work Plan.			

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The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS) Interactive Review Tool (IRT): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.	Not Applicable - NCQA Health Plan Accreditation First Survey scheduled for submission on February 7, 2017. Anthem submitted evidence of preparation for NCQA accreditation, including the 2016 NCQA Standards Readiness Tool Kentucky, and an email from NCQA to Anthem regarding an introductory call, as well as additional supporting evidence in the KY 2016 Work Plan.	Full	This requirement is addressed by the certificate of accreditation, the NCQA accreditation letter dated 4-11-2017, the NCQA First Survey Results ISS Screenshot, and the NCQA First IRT Results. Next Accreditation due 2020 and reviewable 2021	
Annually, the Contractor shall submit the QAPI program description document to the Department in accordance with a format and timeline specified by the Department, after consultation with the Contractor.	Full - Evidence in support of this requirement was found in the 2016 Quality Management Program Description dated 3/31/16 for QMC approval.			
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 - Evidence in support of this requirement was found on page 4 of the 2016 Quality Management Program Description, with implementation supported by the MCO's submission of the baseline SMI/PH PIP, the Prenatal Smoking PIP proposal and the Interim Safe Use Antipsychotics PIP. The MCO has addressed the data integrity issues identified by the EQRO regarding the performance measures, and also provided supporting documentation regarding revisions to measurement and reporting of the ED PIP performance indicators.			

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The Contractor shall collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.	Full - Evidence in support of this requirement is addressed in the 2016 Quality Management Program Description, with implementation supported in the Program Evaluation, which addressed data analysis and identified barriers and opportunities for improvement. Implementation was also supported by the MCO's submission of the baseline SMI/PH PIP, the Prenatal Smoking PIP proposal and the Interim Safe Use Antipsychotics PIP. As above, the MCO has addressed the data integrity issues identified by the EQRO regarding the performance measures, and also provided supporting documentation regarding revisions to measurement and reporting of the ED PIP performance indicators.			
The Contractor shall also have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	New Requirement	Full	This requirement is addressed in the Identification and Assessment of Individuals with Special Healthcare Needs-KY Policy.	
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols;	Full - Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results) Evidence in support of this requirement was found in the 2016 Program Evaluation Report 85.		Includes review of MCO Report #85 QI Plan & Evaluation (see Quarterly Desk Audit results).	

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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.				
22.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.	Full - Anthem has submitted documentation requested by the External Quality Review Organization (EQRO) for PIPs and PM validation. As of 1/17/17, MCO charts have not been submitted for the Hepatitis C focused study; however, an extension was granted.			

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The Contractor shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.	Full - As noted above, Anthem has submitted documentation requested by the External Quality Review Organization (EQRO) for PIPs and PM validation.			
22.4 EQR Administrative Reviews				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.	Full - The MCO has cooperated with all requests related to the compliance review, despite data limitations as described above.			
The Contractor shall assist the Department and the 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	Full - Anthem submitted eligible populations, provider and member information and medical records as requested by the EQRO.			

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chart review shall be the responsibility of the Contractor.				
22.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:	Full - Evidence in support of this requirement was found in the policy entitled, "Corrective Action—Regulatory Audits-KY."			
A. Assign a staff person(s) to conduct follow-up concerning review findings;	Full - Evidence in support of this requirement was found in the policy entitled, "Corrective Action—Regulatory Audits-KY."			
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan;	Full - Evidence in support of this requirement was found in the policy entitled, "Corrective Action—Regulatory Audits-KY"; with evidence that the QMC committee was informed in the June 22, 2016 meeting minutes. Ongoing QM monitoring is supported by subsequent QMC meeting minutes for 7/21/16 and 9/14/16.			
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	Full - The MCO states that "Anthem submitted our corrective action plan to DMS on 6.1.16. We received conditional approval from DMS on 6/24/16. We did a partial update and review with DMS during our CAP/LOC meeting on 11/16/16. Since we were unable to complete review of the entire corrective action, we are scheduled to finish the review during the next CAP/LOC meeting. This does not take place until January 2017."			

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notification; An extension to submit may be extended in accordance with Section 40.4.D;				
D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and	Full - This requirement is addressed on Page 20 of the QI Program Description, with evidence of monitoring improvement of outcomes in the HEDIS2017_Admin_ KY_ MCD_Agg_Nov2016 document. The latter document indicates improved annual performance rates, e.g., adult and pediatric BMI assessment, as well as decrease rates, e.g., PCP access for children aged 7-11 and diabetes monitoring for members with SMI. On site, the MCO addressed EQRO-identified issues regarding ED/PCP PIP reporting accuracy and interpretation.			
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 - Anthem has not expressed disagreement with any of the findings from the 2015 EQR review.	Not Applicable	The MCO has not expressed disagreement with any of the findings from the 2017 EQR review.	
19.3 QAPI Plan			Includes review of MCO report #17 QAPI Work Plan, MCO Report #84 QAPI Program Description, MCO Report #21 MCO Committee Activity, and MCO Report #85 QI Plan and Evaluation (see Quarterly Desk Audit results).	
The Contractor shall have a written QAPI work plan that	Full - Anthem submitted its 2016 QM Work Plan.			
outlines the scope of activities and	Full - This requirement is addressed in the 2016 Work Plan. There are tabs for the various activities-HEDIS, Member Experience, Workgroups, QM Initiatives, and Outreach Programs.			

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the goals,	Full - This requirement is addressed in the 2016 Work Plan. Goals are set for HEDIS performance measures, member experience and Performance Improvement Projects.			
objectives, and	Full - This requirement is addressed in the 2016 Work Plan. The NCQA Standards tab includes a column for objectives.			
timelines for the QAPI program.	Full - This requirement is addressed in the 2016 Work Plan. The NCQA Standards tab includes a column for timeframes.			
New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.	Full - The 2016 QM Work Plan contains columns for timeframes that includes annual and quarterly timeframes, with additional quarterly columns to indicate updates and comments.			
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 - This requirement is addressed on pages 9-10 of the Quality Program Description. The QIC meeting minutes address the QM Description and the QM Work Plan; and QM updates are shared with the QMC. In addition, the QM Program Evaluation document indicated MAC and QMC approval on 6/2/9/16 and 7/20/16, respectively.			
designation of an accountable entity within the organization to provide direct oversight of QAPI;	Full - This requirement is addressed on pages 9-10 of the 2016 Quality Program Description. The QIC meeting minutes for March, August, and November of 2016 address the QM Description and the QM Work Plan. QM updates are shared with the QMC, as indicated in the QMC meeting minutes for March, June, July and September 2016. The QIC meeting minutes indicate attendance that includes, but is not specific to the KY entity, as other state entities are listed as participants.			

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	On site, the MCO explained that this requirement is addressed by the "Trilogy" documents, i.e., QI Program Description, QI Work Plan and QI Evaluation, which were reviewed by the auditor and support this requirement. The MCO also explained that by learning what works in other states, the MCO could apply findings from the Enterprise committee (corporate) to local outreach efforts.			
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;	Full - The QIC meeting minutes for March, August and November of 2016 address the QM Description and the QM Work Plan. QM updates are shared with the QMC, as indicated in the QMC meeting minutes for March, June, July, and September 2016.			
review on an annual basis of the QAPI program; and	Full - This requirement is addressed in the QM Program Description on page 9, and is also supported by the QMC meeting minutes for March, June, July, and September 2016.			
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.	Full - The QMC meeting minutes document discussion of QM program strengths and opportunities identified through performance improvement data analysis, with interventions taken to address identified issues.			
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.	Full - As indicated above, the QMC Committee Minutes demonstrate that this requirement has been met.			
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	Full - The QMC Meeting Agendas indicate that they contain both physical health and behavioral health disciplines. On site, the MCO identified those QMC meeting participants with experience with individuals with Special Health Care Needs, including children.			

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individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.				
The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.	Full - This requirement is met in the QMC meeting minutes for March, June, July and September 2016.			
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.	Full - This requirement is address on page 13 of the Provider Manual, and is further supported by provider interventions indicated in the PIPs.			
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and	Full - This is addressed on Page 5 of the QM Program Description, and supported by the QMC Meeting agendas and minutes.			

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Provider Services in its QAPI program.				
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities, including, but not limited to, monitoring and evaluation of Member's care and services, including the care and services of Members with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving Members in QAPI initiatives and conducting performance improvement projects. Written documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.	Full - Anthem provided an updated organizational chart, with implementation evidenced in the "Workgroups" tab of the 2016 QM Work Plan.			
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 2016 QM Work Plan provides evidence in support of this requirement. On site, the MCO provided a screenshot with explanation to document and support submission in accordance with a timeline.			
19.4 QAPI Monitoring and Evaluation				
The Contractor, through the QAPI program, shall monitor and evaluate the quality of health care on an ongoing	Full - This requirement is addressed throughout the 2016 QM Program Description, QM Program Evaluation, QM Work Plan, and the PIPs that the MCO is working on DMS and EQRO on	Full	The previous recommendation regarding including language on ensuring data integrity is satisfied in the following documents: Anthem KY BH Collaborative	

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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.	12/20/16. On site, the MCO discussed progress on data integrity issues as it pertains to PMs and PIPs. **Recommendation for Anthem** PIP reports should include a paragraph in the procedures section that explains how data integrity is ensured for both performance indicators and intervention tracking/process measures.		Antipsychotic Meds PIP_2018 Extended Final Submission, Anthem PIP Prenatal Smoking interim 2018 submission, CCS PIP_interim2018 submission, PIP Annual Dental Visits in EPSDT Population final submission, Revised ED PIP Final Submission_20171130_lgf, and SMI PIP final submission_2018.	
Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.	Full - The Provider Quality Incentive Program Description 2016, the CPGs Matrix and CPG Update provides evidence of structures in places for this requirement, and PIP provider interventions for distributing care gap reports to providers support communication. On site, the MCO provided a Performance Medicaid Scorecard Summary for a provider group that demonstrates how provider performance is measured against practice guidelines standards, i.e., HEDIS performance indicators for preventive visits, cervical			

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	cancer screening, breast cancer screening, diabetes management and asthma medication management.			
Areas identified for improvement shall be tracked and corrective actions taken as indicated.	Full – On site, the MCO provided the "Year – end report from the medical records audit.			
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 – On site, the MCO provided the "year-end report from the medical records audit;" however, findings will not be reviewed by QMC and MAC until January 2017. **Recommendation for Anthem** Present evidence of QMC and MAC monitoring of corrective actions identified from the medical records audit for next year's compliance review.	Full	For IPRO reviewer: Please review QMC and MAC as stated in prior year results. The following documents addressed the previous recommendations: Anthem BCBS KY Medicaid QM Program Evaluation, Kentucky QMC Agenda 7.7.17, QMC-3.26.18 Meeting Minutes, and QMC-6.29.18 Meeting Minutes.	
The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.	Not Applicable - The MCO indicated that "the year-end report will be reviewed by QMC and MAC committees in January 2017." **Recommendation for Anthem** Present evidence of QMC and MAC review of data and/or systems issues identified from the medical records audit for next year's compliance review.	Full	For IPRO reviewer: Please review QMC and MAC as stated in prior year results The following documents address the requirement to use multidisciplinary teams to analyze and address data or systems issues: Anthem BCBS KY Medicaid QM Program Evaluation, Kentucky QMC Agenda 7.7.17, QMC-3.26.18 Meeting Minutes, and QMC-6.29.18 Meeting Minutes.	
The Contractor shall collaborate with existing provider quality improvement activities and to the extent possible, align with those activities to reduce duplication and to maximize outcomes.	Full - This requirement is addressed in the PQIP Agreement and in the PQIP Program Description. **MCO Response:** Anthem respectfully contends this requirement is met for the following reason:			

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	Documentation of implementation was presented while on site. Please see attached email surrounding the request and the document given while on site. Documentation embedded is not new information; please find Excel document evidence under: File location: 2017 Preliminary Response – Tool 1 – page 60 FW IPRO needs PCMS Reporting **Final Review Determination** The attached PCMS Report documents full compliance with this requirement. Review determination revised from Substantial to Full.			
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 PIP proposals, baseline PIPs, and Interim PIPs.			
The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members and Potential Enrollees upon request.	Full - This requirement is addressed on page 8 of the QM Program description, the QM Work Plan, page 92 of the QM Program Evaluation, and the CPG matrix, page 62 of the Provider Manual, with evidence of CPG discussion in QIC Meeting minutes. New Requirement	Full	This requirement is addressed in the following: 2018 Medicaid QM PD (pages 6 and 15); the Clinical Practice Guideline matrix located on the provider website; Anthem Provider Manual 2017; and 2017 Medicaid QI Program Evaluation.	
Mental Health and Substance Use practice guidelines shall also be submitted to the Department and	Full - Evidence in support of this requirement was found in the WEBPAKY-0059-16 Anthem CPG Update_RFRF, which documented review and adoption of multiple CPGs, e.g., ADHD,			

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DBHDID.	autism, behavioral health screening and treatment, screening and behavioral counseling in primary care to reduce alcohol misuse, screening for depression, bipolar disorder in adults, bipolar disorder in children/adolescents. On site, the MCO explained that CPGs were submitted to DCBS who submits to the Department.			
The guidelines shall be based on valid and reliable medical/behavioral health evidence or consensus of health professionals;	Full - This requirement is addressed in the QM Program Description and the CPGs Matrix, which cite sources for each guideline that are nationally recognized and evidence-based.			
consider the needs of Members;	Full - This requirement is addressed in the QM Program Description and the QM Program Evaluation, with evidence of communication on Page 25 of the Provider Manual and of implementation in the CPG Matrix and MAC Committee minutes.			
developed or adopted in consultation with contracting health professionals, and	Full - This requirement is addressed in the QM Program Evaluation, in the QM Program Description and in Appendix A GBD Committee Structure, which identifies the MAC as responsible for reviewing guidelines. MAC review of guidelines is evident in minutes.			
reviewed and updated periodically.	Full - This requirement is addressed in the QM Program Description and the QM Work Plan. Dates of review and presentation to committees are documented in the CPG Matrix, with evidence of proposed guidelines for behavioral health and CDC Guideline for Prescribing Opioids for chronic Pain submitted for committee review per the August 9, 2016 CPG update.			
Decisions with respect to UM, member education, covered services, and other	Full - This requirement is addressed in the QM Program Evaluation.			

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areas to which the practice guidelines apply shall be consistent with the guidelines.	On site, the MCO provided the policy for Delivery of Health Education Programs and Services-KY and the policy for Clinical Criteria for Utilization Management Decision-Core Process.			
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at health improvement for selected performance measures, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.	Full - Evidence in support of this requirement was found in the 2016 Program Evaluation and in the 2016 Work Plan, as well as in the 2016 CAHPS Comments Content Analysis; as well as the MCO's having addressed data integrity concerns since the 12/2016 meeting.			

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**
Additionally, the Department, Contractor, and the EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.	Full - The MCO followed the HEDIS rotation schedule.			
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to Individual Members with Special Health Care Needs (ISHCN).	Full - Report #96 documents measurement and comparison of 2014/2015 rates for members with special health care needs, including diabetes, low back pain and COPD.			
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.	Full - Report #96 showed improved rates for PCP access among children aged 25 months to 6 years, cervical cancer screening, medical attention for nephropathy, prenatal care, FUH, imaging for low back pain. In response to decreased rates for HbA1c testing, the MCO identified the following strategies/actions taken: diabetes workgroup interventions for members and providers included the following: Eyequest to educate providers regarding eye exams with linkage to HbA1C; medical record review for missing claims and resultant provider education.			
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	Substantial - Report 96 indicates performance targets for HEDIS and KY performance measures, and stratified data was provided for the metabolic monitoring measure for the ADC Affinity Group; however, stratified data was not provided comprehensively for HEDIS and KY performance measures.	Full	This requirement was addressed after last year's recommendation was implemented in these documents: PHM 2BC 2018 Pop Assessment FINAL; CLAS and Health Disparities Program Evaluation_final; and each of the performance improvement projects (PIPs).	

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**
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.	**Recommendation for Anthem** Trilogy documents should present stratified data, and the Program Evaluation should interpret this data with regard to identifying disparities in health care and plans to reduce disparities. **MCO Response:** Agree with finding. Anthem will stratify data on every HEDIS measure as opposed to those NCQA stratifies. This information will be included in the 2017 Program Evaluation to identify any disparities along with the population assessment.			
20.3 Reporting HEDIS Performance Measures			Includes review of MCO Report #96 Audited HEDIS Reports (see Quarterly Desk Audit results).	
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than each August 31st.	Full - Anthem submitted Report #96, which includes the HEDIS IDSS 2015-16 Rate Comparison.			
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	Full - Anthem submitted Report #96, which includes the HEDIS IDSS 2015-16 Rate Comparison.			

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**
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.				
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.	Full - October 2017 Review Findings This requirement is addressed in the document "HEDIS Audited Report Summary.xls." January 2017 Review Findings Minimal - No stratified data was provided other than the ADC metabolic monitoring data. **Recommendation for Anthem** Trilogy documents should present stratified data. **MCO Response:** Agree with finding. Anthem will stratify data on every HEDIS measure as opposed to those NCQA stratifies. This information will be included in the 2017 Program Evaluation to identify any disparities along with the population assessment.			
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,	Not Applicable - DMS has not chosen a subset of measures for evaluation. Annually, in collaboration with the EQRO, DMS evaluates the measures required for reporting.	Not Applicable	The MCO indicated on site that there were no measures identified by DMS.	

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**
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.				
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.	Not Applicable - DMS has not chosen a subset of measures for evaluation. Annually, in collaboration with the EQRO, DMS evaluates the measures required for reporting.	Not Applicable	The MCO indicated on site that there were no measures identified by DMS.	
The Department further reserves the right to implement and require different quality measures. The Contractor shall be given no less than ninety (90) days to comply with any new quality measurement requirement.	New Requirement	Not applicable	The MCO indicated on site that there were no measures identified by DMS.	
20.4 Accreditation of Contractor by National Accrediting Body				
If the Contractor holds a current NCQA accreditation status it shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including	Full - NCQA Accreditation First survey scheduled for submission on February 7, 2017. Evidence in support of this requirement was found in the 2016 NCQA Standards Readiness Tool Kentucky and the NCQA Survey Introductory Call_Anthem.			

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**
scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Review Tool (IRT) Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department				
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the Contractor shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of its initial MCO contract with the Commonwealth.	Full - NCQA Accreditation First survey scheduled for submission on February 7, 2017.			
20.5 Performance Improvement Projects (PIPs)			Includes review of MCO Reports #19 PIPs, #90 PIP Proposal, and #92 PIP Measurement (see Quarterly Desk Audit results).	
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a	Full - Anthem submitted its annual PIP proposals and PIP reports as required.			

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**
condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristics and health risks; and the interest of Members in the aspect of care/services to be addressed.				
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	Full - This requirement is met by submission of PIP proposals as directed by DMS.			

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs of Members with conditions and illnesses that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to Members and Providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.				
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.	Full - Participation by government agency staff, local health department staff, and other community organizations was seen in the QMAC meeting sign-in sheets. QMAC meeting minutes addressed PIP progress.			
The Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures and establishment of	Full - Anthem is collaborating with DMS and the other MCOs for the Statewide PIPs on Use of Antipsychotic Medications in Children and Adolescents, Preventive Care for Adults with SMI and the Prenatal Smoking PIP; participates in the CMS Smoking Cessation Affinity Group and the CMS/CHCS EPSD Dental Quality QI Training group.			

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**
relationship with existing organizations engaged in provider performance improvement through education and training in best practices and data collection.				
The Contractor shall monitor and evaluate the quality of care and services by initiating at least one PIP each year and participating in one collaborative PIP each year. The Department recognizes that the following conditions are prevalent in the Medicaid population in the Commonwealth and recommends that the Contractor considers the following topics for PIPs: diabetes, coronary artery disease screenings, colon cancer screenings, cervical cancer screenings, behavioral health, reduction in ED usage and management of ED Services. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department shall require Contractor to (i) implement an additional PIP specific to the Contractor, if findings from an EQR review or audit	Full - As described, Anthem submitted new and revised PIPs as requested.			

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**
indicate the need for a PIP, or if directed by CMS;. The Contractor shall submit reports on PIPs as specified by the Department.				
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:	Full - Anthem reported its PIP proposals and baseline reports using the new PIP templates.			
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.			
C. Goals;	Full - Evidenced in the Aims/Objectives/Study Question for each PIP.			
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 described the interventions planned and implemented for each of the PIPs. In some cases, DMS and IPRO made recommendations regarding the interventions, as well as process measures.			
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.	Substantial - In the PIP for safe antipsychotic use, the MCO interpreted an increased from 0% during the year when there was no eligible population to 22.41% as improvement for the APM measure; however, this is an incorrect interpretation because the only reason the rate appeared to have "improved" is that there was no data for the baseline period.	Full	This requirement is addressed in the following documents: Anthem KY BH Collaborative Antipsychotic Meds PIP_2018 Extended Final Submission; Anthem PIP Prenatal Smoking interim 2018 submission; CCS PIP_interim2018 submission; PIP Annual Dental Visits in EPSDT Population final	

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 the PIP to reduce ED visits/increase PCP visits, some performance indicators specify numerator and denominators and other do not; nor do the process/intervention tracking measures specify numerators and denominators. In addition, target rates should be set per instructions in the new PIP template, but not using hypothesis testing because the baseline, interim and final samples are not independent. On site, the MCO acknowledged that the interpretation of improvement was incorrect and also provided specifications for PIP numerators and denominators. **Recommendation for Anthem** PIPs due in 2017 should address correct measure specification and interpretation. **MCO Response:** Agree with finding. Anthem will remove the term "improvement" from the PIP as this is not indicative of the first measurement period due to no previous denominator or reportable rate.		submission; Revised ED PIP Final Submission_20171130_lgf; and SMI PIP final submission_2018.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;	Not Applicable - There are no PIP reports in the Final phase.	Full	This requirement is addressed in the following documents: Anthem KY BH Collaborative Antipsychotic Meds PIP_2018 Extended Final Submission; PIP Annual Dental Visits in EPSDT Population final submission; Revised ED PIP Final Submission_20171130_lgf; and SMI PIP final submission_2018.	

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**
B. Did Members participate in the performance improvement project;	Full - Member participation is evident in the interventions.			
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;	Not Applicable - There are no PIP reports in the Final phase.	Substantial	"SMI PIP final submission_2018" – Was the total spent during the PIP $9,000 or $12,000? "Revised ED PIP Final Submission_20171130_lgf" – There is no description for the table in the Financial Impact Section. **Recommendations for MCO** The MCO should clarify the total spent in "SMI PIP final submission_2018." The MCO should include a description for the table in the Financial Impact Section in "Revised ED PIP Final Submission_20171130_lgf." **Final Review Determination** No change in final determination. MCO documentation is due to IPRO by the end of the last day of the audit. This date for Anthem was 10/17/18. Documentation received after this time can't be used for review.	**Anthem Response** Anthem's interim Quality Director discussed thoroughly the deficiencies and was approved by the auditor to submit post onsite (submitted 10/18/18 & 10/19/18) the revised SMI PIP and ED PIP with corrections. **SMI PIP:** For the total, the table incorrectly showed $9,000 and was revised to state $6,000 (red font) for a total spend of $9,000. **ED PIP:** Additionally, the Revised ED PIP Final Submission was submitted 10/18/18. The Financial Impact on page 56 was added (red font).
D. How financial impact might determine sustainability of	New Requirement	Substantial	Sustainability is addressed in the three following final reports: Anthem KY BH Collaborative Antipsychotic	**Anthem Response** Anthem's interim

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Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
improvement achieved;			Meds PIP_2018 Extended Final Submission; PIP Annual Dental Visits in EPSDT Population final submission; and Revised ED PIP Final Submission_20171130_lgf. Sustainability is not addressed in "SMI PIP final submission_2018." **Recommendations for MCO** The MCO should discuss sustainability of the project in "SMI PIP final submission_2018." **Final Review Determination** No change in determination. The documentation provided did not address the contract requirements.	Quality Director discussed thoroughly the deficiencies and was approved by the auditor to submit post onsite (submitted 10/19/18) the revised SMI PIP with corrections. **SMI PIP:** The revised SMI PIP includes added sustainability language on page 50 (red font).
E. Were the results and conclusions made available to members, providers and any other interested bodies;	Not Applicable - There are no PIP reports in the Final phase.	Full	Results for all but the Emergency Department PIP (which closed in Q3 2018, not 2017) will be made available to the Member Advisory Committee (MAC) and Quality and Member Access Committee (QMAC) in Q4 2018.	
F. Is there an executive summary;	Not Applicable - There are no PIP reports in the Final phase.	Full	This requirement is addressed by the PIP abstracts, which function as executive summaries.	
G. How could findings be reported to a broad audience of relevant stakeholders or the general public; and	New Requirement	Full	This requirement is addressed in the Dissemination of Findings sections of each of the four final PIP reports: Anthem KY BH Collaborative Antipsychotic Meds PIP_2018 Extended Final Submission; PIP Annual Dental Visits in EPSDT Population final submission;	

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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**
			Revised ED PIP Final Submission_20171130_lgf; and SMI PIP final submission_2018.	
H. Do illustrations – graphs, figures, tables – convey information clearly?	Substantial - In the Interim PIP for safe antipsychotic use, the MCO interpreted an increased from 0% during the year when there was no eligible population to 22.41% as improvement for the APM measure; however, this is an incorrect interpretation because the only reason the rate appeared to have "improved" is that there was no data for the baseline period. In the Interim PIP to reduce ED visits/increase PCP visits, some performance indicators specify numerator and denominators and other do not; nor do the process/intervention tracking measures specify numerators and denominators. In addition, target rates should be set per instructions in the new PIP template, but not using hypothesis testing because the baseline, interim and final samples are not independent. As above, on site, the MCO acknowledged that the interpretation of improvement was incorrect and also provided specifications for PIP numerators and denominators. **Recommendation for Anthem** As above, PIPs due in 2017 should address correct measure specification and interpretation. **MCO Response:** Agree with finding. Anthem will remove the term "improvement" from the PIP as this is not indicative of the first measurement period due to no previous denominator or reportable rate.	Full	This requirement is addressed in the four final PIP reports: Anthem KY BH Collaborative Antipsychotic Meds PIP_2018 Extended Final Submission; PIP Annual Dental Visits in EPSDT Population final submission; Revised ED PIP Final Submission_20171130_lgf; and SMI PIP final submission_2018.	
Performance reporting shall utilize	Full - Addressed in the PIP proposals, baseline and interim			

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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**
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	reports.			
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:	Substantial - In the Interim PIP for safe antipsychotic use, the MCO interpreted an increased from 0% during the year when there was no eligible population to 22.41% as improvement for the APM measure; however, this is an incorrect interpretation because the only reason the rate appeared to have "improved" is that there was no data for the baseline period. In the Interim PIP to reduce ED visits/increase PCP visits, some performance indicators specify numerator and denominators and other do not; nor do the process/intervention tracking measures specify numerators and denominators. In addition, target rates should be set per instructions in the new PIP template, but not using hypothesis testing because the baseline, interim and final samples are not independent. As above, on site, the MCO acknowledged that the interpretation	Full	This requirement is addressed in the following six PIP reports: Anthem KY BH Collaborative Antipsychotic Meds PIP_2018 Extended Final Submission; Anthem PIP Prenatal Smoking interim 2018 submission; CCS PIP_interim2018 submission; PIP Annual Dental Visits in EPSDT Population final submission; Revised ED PIP Final Submission_20171130_lgf; and SMI PIP final submission_2018.	

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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**
	of improvement was incorrect and also provided specifications for PIP numerators and denominators. **Recommendation for Anthem** As above, PIPs due in 2017 should address correct measure specification and interpretation. **MCO Response**: Agree with finding. Anthem will remove the term "improvement" from the PIP as this is not indicative of the first measurement period due to no previous denominator or reportable rate.			
A. Project Proposal including baseline measurement – due September 1 of Contract year. Proposal with baseline measurement is required upon submission of completed PIP. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.	Full - As noted previously, Anthem submitted its PIP proposals as required.			
B. 1st Remeasurement – no more than one calendar year after baseline measurement and no later than September 1 of the Contract year following baseline measurement.	Full - As noted previously, Anthem submitted its PIP proposals as required.			
C. Conclusion – no more than one calendar year after the first remeasurement and no later than	Not Applicable - Anthem's PIPs are in the proposal, baseline and interim, but not final, phases.	Full	This requirement is addressed in the four final PIP reports: Anthem KY BH Collaborative Antipsychotic Meds PIP_2018 Extended Final Submission; PIP	

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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**
September 1 of the contract year when the PIP concludes.			Annual Dental Visits in EPSDT Population final submission; Revised ED PIP Final Submission_20171130_lgf; and SMI PIP final submission_2018. All four were submitted no later than September 1 of the contract year.	
20.6 Quality and Member Access Committee			Includes review of MCO Report #21 MCO Committee Activity and MCO Report #84 QAPI Program Description (see Quarterly Desk Audit results).	
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 - Evidence in support of this requirement was found in the policy entitled, "Quality and Member Advisory Committee." Report #1 included member sign-in sheets that showed member attendance for 3 of the 8 QMAC regional meetings, with Region 5 having the most members (6) and Regions 1 and 3 having 1 and 2, respectively. Advocates such as KY Cares and hospital advocates also attended. The MCO also provided a sample invitation and member mailing labels in support of implementation of this requirement. There was a single set of minutes for one meeting for each of 8 regions. **Recommendation for Anthem** Utilize PIPs to engage member participation by recruiting members to participate in PIP focus groups for identification of barriers to receipt of recommended care. Ask members who participated in PIP focus groups to also participate in QMAC meetings.			
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender,	Full - Appendix A of the 2016 QM PD indicates that membership will be comprised of "Health Plan Members from the major cultural groups served by the plan." Members are recruited using a random sample, so theoretically, should represent the			

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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**

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:	population however.
	
	MCO Response: Anthem respectfully contends this requirement is met for the following reasons:
	Requirement:
	"Member participation may be excused by the Department **upon a showing by Contractor of good faith efforts to obtain Member participation**."
	Demonstration:
	Without guidance to the contrary, Anthem demonstrates our good faith efforts using the annual EQR audit conducted by IPRO. Anthem demonstrated our participation outreach is 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.
	
	• 8 QMAC meetings were held in 2016
	• 2 meetings per quarter; 2 regions per quarter
	• Different types of locations; different times of day
	• Approximately 300 invitations go out requesting participation to an upcoming regional meeting
	  ○ 200 which includes random members from the region and targeted grievance members* in that region and community advocates
	  ○ 100 additional members are invited in the zip code where the meeting is held
	*Anthem demonstrated we went a step further to outreach those that have used their voice already in filing a grievance in the past to make sure they have the opportunity to contribute.			

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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 above was demonstrated via policy and during discussion in the interview. **Final Review Determination** A review of Anthem's response supports a change in the Review Determination from Substantial to Full compliance with this requirement.			
A. Providing review and comment on quality and access standards;	Full - This requirement is addressed on page 10 of the QM Program Description, and QMAC meeting minutes address member access to services, e.g., dental, behavioral health, EPSDT.			
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. QMAC meeting agenda addresses Grievances and Appeals.			
C. Providing review and comment on Member Handbooks;	Full - October 2017 Review Findings This requirement is addressed in the QMAC Meeting Minutes titled "Region 5 – QMAC Meeting Minutes 04-27-17 & Northern KY – QMAC Meeting Minutes 03-04-17." January 2017 Review Findings Minimal - This requirement was not specifically addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC, nor did any of the QMAC meeting minutes indicate in the "Handouts" section that the Member Handbooks were provided to members for feedback.			

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**
	On site, the MCO explained that they use other means to obtain member feedback, e.g., by soliciting information from members with related grievances, such as billing problems. **Recommendation for Anthem** Ask QMAC member participants for their feedback on the Member Handbook. **MCO Response: Agree:** Anthem does discuss member handbooks during QMAC meetings but beginning in 2017 Anthem will have hard copies of the handbooks available to all participants to review and give specific feedback per section and reflect this in the meeting minutes. In addition, this requirement will be added to the Program Description, Appendix A.			
D. Reviewing Member education materials prepared by the Contractor;	Full - This requirement is addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. In addition, the "Handouts" section of the QMAC meeting minutes indicated that Anthem brochures and flyers regarding benefits were shared with attendees, which included members.			
E. Recommending community outreach activities; and	Full - This requirement is addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that discussion of community outreach activities occurred.			
F. Providing reviews of and comments on Contractor and Department policies that affect Members.	Full - This requirement is addressed in the QM PD, Appendix A, Kentucky Health Plan Committee Structure, QMAC. The meeting minutes reflect that in most of the meetings, participants commented and asked questions about Medicaid and Anthem policies.			

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 list of the Members participating with the QMAC shall be submitted to the Department annually.	Full - Anthem submitted the sign in sheets for the QMAC regional meetings.			
21.5 Assessment of Member and Provider Satisfaction and Access			Includes review of MCO Report #94 Member Surveys and Report #95 Provider Surveys (see Quarterly Desk Audit results).	
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.	Full - Anthem submitted Report #94, CAHPS survey results for Adult Medicaid and Child Medicaid CAHPS, including the full report from its vendor, DSS Research, which contains the CAHPS questionnaire. Anthem indicated in Report #95 that the Provider Satisfaction Survey was being conducted in 2016; with results for the 2015 survey provided, as the 2016 survey aggregate final date "TBD." On site, the MCO provided the 2016 provider Satisfaction survey results.			
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.	Full - Anthem submitted Report #94, CAHPS survey results for Adult Medicaid and Child Medicaid CAHPS, including the full report from its vendor, DSS Research, which contains the CAHPS questionnaire.			
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and	Full - The Anthem Kentucky Access to Care Report 1 27 16 documents that this requirement has been met.			

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**
experience with access, treatment and services.				
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool.	Full - Evidence in support of this requirement was provided in the screenshot document "Posting 5.23.16 PSAT Tool.png."			
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.	Full - The CAHPS report details survey findings and methodology.			
All survey results must be reported to the Department, and upon request, disclosed to Members.	Full - Anthem submitted Report #94 CAHPS report.			
38.5 QAPI Reporting Requirements The Contractor shall provide status	Full - Includes review of MCO Report #16 Summary of QI Activities and MCO Report #17 QAPI Work Plan (see Quarterly		Includes review of MCO Report #16 Summary of QI Activities and MCO Report #17 QAPI Work Plan (see	

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reports 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.	Desk Audit results) The MCO submitted Reports #16 and 17.		Quarterly Desk Audit results).	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial -	Minimal -	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	15	2	0	0
Total Points	45	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial -	Minimal -	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.88**		

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

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

Reports

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

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
25.0 Member Grievances and Appeals				
25.1 General Requirements The Contractor shall have an organized grievance system that shall include- a grievance process, an appeals process, and access for Members to a State fair hearing pursuant to KRS Chapter 13B and 42 CFR 438 Subpart F. The Department shall provide a standardized form for Contractors to utilize for a Member to begin the Contractor's grievance and appeal process.	Deemed for 2017			
25.2 Member Grievance and Appeal Policies and Procedures				
The Contractor shall have a timely and organized Grievance and Appeal Process with written policies and procedures for resolving Grievances filed by Members. The Grievance and Appeal Process shall address Members' oral and written grievances. The Grievance and Appeal Process shall be approved in writing by the Department prior to implementation and shall be conducted in compliance with the notice, timeliness, rights and procedures in 42 CFR 438 subpart F, 907 KAR 17:010 and other applicable CMS and Department requirements. Grievance and Appeal policies and procedures shall include, but not be limited to:	Deemed for 2017			
A. Provide the Member the opportunity to present evidence and allegations of fact or law, in person as well as in writing; The Contractor must inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals and expedited appeals as specified in 42 CFR 438.408(b) and (c);	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Policy.	
B. Provide the Member and the Member's representative the Member's case file, including medical records, other	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Member Appeals and Provider Medical	

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**
documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor, or at the direction of the Contractor, in connection with the appeal of the adverse benefit determination. This information shall be provided, upon request, free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFRC.F.R. 438.408(b) and (c);			Necessity/Administrative Policy.	
C. Take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination;	Deemed for 2017			
D. Consider the Member, the Member's representative, or the legal representative of the Member's estate as parties to the appeal;	Deemed for 2017			
E. A process for evaluating patterns of grievances for impact on the formulation of policy and procedures, access and utilization;	Deemed for 2017			
F. Procedures for maintenance of records of grievances separate from medical case records and in a manner which protects the confidentiality of Members who file a grievance or appeal;	Deemed for 2017			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
G. Ensure that a grievance or an appeal is disposed of and notice given as expeditiously as the Member's health condition requires but not to exceed 30 days from its initiation; If the Contractor extends the timeline for an appeal not at the request of the Member, the Contractor shall make reasonable efforts to give the Member prompt oral notice of the delay and shall give the Member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the enrollee of the right to file another grievance if he or she disagrees with that decision. Additionally, if the Contractor fails to resolve an appeal within this 30-day timeframe, the Member is deemed to have exhausted the Contractor's internal appeal process and may initiate a State Fair Hearing;	Deemed for 2017 New Requirement	Full	Includes member grievance – random, member grievance – quality, and member appeal file review results. This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy. **Member Grievance – Random File Review Results** Ten (10) of 10 files contained the required timeliness. No files required extensions. **Member Grievance – Quality File Review Results** These files were not reviewed in 2018. **Member Appeal File Review Results** Ten (10) of 10 files contained the required timeliness. No files required extensions.	
H. Ensure individuals who make decisions on grievances and appeals were not involved in any prior level of review;	Full - Includes Member Grievance Random, Member Grievance Quality and Member Appeal file review results This requirement is addressed in Policy and Procedure Member Complaints and Grievances page 10 and Member Appeals-KY page 7. Member Grievance File Review Results -Random		Includes member grievance – random, member grievance – quality, and member appeal file review results.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Of 10 reviewed files, 1/10 involved a potential clinical quality concern. This member's case was recognized as a potential quality of care concern by DentaQuest after the grievance was received by Anthem from the Aunt of an adolescent member who had eight (8) dental fillings in the course of one day. DentaQuest is monitoring the practice and physician in question. It is not clear from documentation if the investigation is closed. <u>Member Grievance File Review Results -Quality</u> 10/10 quality member grievance files were appropriately reviewed by a health care professional for medical necessity. <u>Member Appeal File Review Results</u> 10/10 member appeal files were appropriately reviewed by a health care professional for medical necessity. **MCO Response:** Anthem respectfully contends that this meets full compliance. This specific dental case was not addressed while onsite during the interview and no file number was			

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**
	left for Anthem to review. With discussion at the onsite, Anthem's response would have been: "While Quality closes the grievance after investigation, FWA continues to monitor. This why it is stated in the record that "DentaQuest is monitoring the practice and the physician in question." Please note the highlighted section below for evidence that Anthem, through DentaQuest, continues to have this case open and monitor. While the date of **2/15/17** for the 2nd round of report review for FWA is new information, the preliminary report for this EQR audit was not received prior to 2/17/17. No closure of the FWA would have been noted in 2016. The case was closed on 9/07 from an open grievance. The grievance was placed with quality and FWA to monitor. The Clinical review and FWA review are noted below. Clinical Quality Review Response: It all depends…….. It is not unheard of to complete this many restorations at			

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**
	one visit, but usually there is some type sedation given, unless it is an older/ very cooperative patient. Under general anesthesia/in OR setting even more than 8 restorations at one visit is not uncommon. We do not dictate how much treatment the provider completes, that is solely up to them, their training, their comfort level for doing multiple restorations at one visit, and the cooperation of the patient… We frequently monitor to see if the provider has a history of completing multiple one and two surface restorations per visit as some providers will bill for restorations when they are using the composite material as more of a sealant than a restoration. e clinical quality review from the Dental Director: FWA Overview: **DQ ran reports on September 8, 2016 and February 15, 2017 and found no aberrant patterns.** It was determined that no FWA case needed to be pursued. **Final Review Determination** Based on Anthem's response that DQ ran reports on September 8, 2016 and February 15, 2017 and found no aberrant patterns, the final review			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	determination is changed to full.			
I. If the grievance involves a Medical Necessity determination, ensure that the grievance and appeal is heard by health care professionals who have the appropriate clinical expertise;	Deemed for 2017			
J. Process for informing Members, orally and/or in writing, about the Contractor's Grievance and Appeal Process by making information readily available at the Contractor's office, by distributing copies to Members upon enrollment; and by providing it to all subcontractors at the time of contract or whenever changes are made to the Grievance and Appeal Process;	Deemed for 2017		Includes member grievance – random, member grievance – quality, and member appeal file review results.	
K. Provide assistance to Members in filing a grievance if requested or needed including, but not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability;	Deemed for 2017 New Requirement	Full	The requirement is addressed in the Member Grievances Procedures – KY Policy.	
L. Include assurance that there will be no discrimination against a Member solely on the basis of the Member filing a grievance or appeal;	Deemed for 2017			
M. Include notification to Members in the Member Handbook regarding how to access the Cabinet's ombudsmen's office regarding grievances, appeals and hearings;	Deemed for 2017			
N. Provide oral or written notice of the resolution of the grievance in a manner to ensure ease of understanding;	Deemed for 2017		Includes member grievance – random and member grievance – quality file review	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			results.	
O. Provide for an appeal of a grievance decision if the Member is not satisfied with that decision;	Deemed for 2017			
P. Provide for continuation of services, if appropriate, while the appeal is pending;	Deemed for 2017			
Q. Provide expedited appeals relating to matters which could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain or regain maximum function;	Deemed for 2017			
R. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals to establish the earliest possible filing date for the appeal and must be confirmed in writing;	New Requirement	Full	This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy.	
S. Not require a Member or a Member's representative to follow an oral request for an expedited appeal with a written request;	Deemed for 2017			
T. Inform the Member of the limited time to present evidence and allegations of fact or law in the case of an expedited appeal;	Deemed for 2017			
U. Acknowledge receipt of each grievance and appeal;	New Requirement	Full	This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy.	
V. Provide written notice of the appeal decision in a format and language that, at a minimum, meet the standards described in 42 90 CFR 438.10 and for notice of an expedited resolution, the Contractor shall also make	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy.	

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**
reasonable efforts to provide oral notice;;				
W. Provide for the right to request a hearing under KRS Chapter 13B;	Deemed for 2017			
X. Allows a Provider to file a grievance or appeal on the Member's behalf as provided in 907 KAR 17.010; and	Deemed for 2017			
Y. Notifies the Member that if a Service Authorization Request is denied and the Member proceeds to receive the service and appeal the denial, if the appeal is in the Contractor's favor, that the Member may be liable for the cost.	Deemed for 2017			
If the Contractor continues or reinstates the Member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: A. The Member withdraws the appeal or request for a State Fair Hearing;, B. The Member does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision, C. A State Fair Hearing decision adverse to the Member is made, or D.	Deemed for 2017			
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, or CMS upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later. The Contractor shall have procedures for assuring that files	Full - Maintenance of grievance files is addressed for appeal files in Member Appeals policy – Quality Monitoring page 12. For Member Grievances and Complaints this requirement is addressed on page 10.			

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**
contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information. Documentation regarding the grievance shall be made available to the Member, if requested.	Reference to storage of grievance files for ten years following final decision was updated in Policies Member Appeals page 12, and Member Complaints and Grievances page 11.			
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)	Deemed for 2017		Includes member grievance – random and member grievance – quality file review results.	
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant that shall include: all information considered in investigating the grievance; findings and conclusions based on the investigation; and the disposition of the grievance. 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 page 10. <u>Member Grievance File Review Results -Random</u> 9/10 random member grievance files were reviewed within the appropriate timeliness standard. The MCO	Full	Includes member grievance – random and member grievance – quality file review results. This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy. **<u>Member Grievance – Random File Review Results</u>** Ten (10) of 10 files met the timeliness standards. No files included requests for extension.	

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**
	acknowledged the non-compliant record and indicated there was an issue in the system that prevented the grievance from routing timely. Member Grievance File Review Results -Quality 10/10 quality member grievance files were reviewed within the appropriate time standard, and contained all information considered in investigating the grievance. **Recommendation for Anthem** Anthem should ensure all inter-departmental processes routing grievances from Member Services to CCQM are monitored for timeliness. **MCO Response:** Agree with this finding. Anthem's processes for routing internal grievances are monitored within the corporate CCQM department for timeliness.		**Member Grievance – Quality File Review Results** These files were not reviewed in 2018.	
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.	Deemed for 2017		Includes member grievance – random and member grievance – quality file review results.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
42 CFR 438.408 (c)				
Appeal File Review				
Within five working days of receipt of the appeal, the Contractor shall provide the Member with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution. KAR 17:010 Section 4 (10) (a) and (b)	Deemed for 2017		Includes member appeal file review results.	
The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. KAR 17:010 Section 4 (7)	Deemed for 2017		Includes member appeal file review results.	
The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe. KAR 17:010 Section 4 (11) and (12)	Deemed for 2017		Includes member appeal file review results.	
The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.	Deemed for 2017		Includes member appeal file review results.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
42 CFR 438.406 (b) (2)				
The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate. 42 CFR 438.406 (a) (3) (4)	Deemed for 2017		Includes member appeal file review results.	
For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information: 1) the results of the resolution process; (2) the date it was completed. KAR 17:010 Section 4 (13) (a) 42 CFR 438.408 (d) (2) and (e)	Deemed for 2017		Includes member appeal file review results.	
The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information: (1) the right to request a state fair hearing and how to do so; (2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and	Substantial - Includes Member Appeal file review results This requirement is addressed in the Member Appeals policy – Notification to Members and Providers of Appeal	Full	Includes member appeal file review results. This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy.	

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**
(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)	Decisions page 8. Anthem provided evidence the appeals resolution letter (dated 11/21/16) which includes notice of the member's potential liability for the cost of continued benefits if the State Fair Hearing upholds the MCO's action. Member Appeal File Review Results 3/10 files were missing the required language that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action in the resolution letter. **Recommendation for Anthem** Anthem should ensure the resolution letter contains all required language regarding member's responsibility to pay for services rendered if the State Fair Hearing decision is upheld prior to sending to the member. **MCO Response:** Anthem agrees with finding. The notification letter was updated during 2016 with some of the files reviewed showing letters before the update.		**Member Appeal File Review Results** Nine (9) of 10 files contained all the required elements; 1 of 10 files had the appeal approved and was designated not applicable for this requirement.	
Expedited Appeals File Review				

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice. KAR 17:010 Section 4 (14) (c)	Deemed for 2017		Includes file review results for member appeals, if expedited.	
The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any 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)	Deemed for 2017		Includes file review results for member appeals, if expedited.	
The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law. 42 CFR 438.406 (b) (2)	Deemed for 2017		Includes file review results for member appeals, if expedited.	
25.3 State Hearings for Members				
A Member may not file a grievance with the state. A Member shall exhaust the internal Appeal process with the Contractor prior to requesting a State Fair Hearing. The Contractor, the Member, or the Member's representative or legal representative of the Member's estate shall be parties to the hearing as provided in 907 KAR 17:010(5). A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the	New Requirement	Full	This requirement is addressed in the Member Appeals and Provider Medical Necessity/Administrative Denial Appeals – KY Policy.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor within forty-five (45) days of the final appeal decision by the Contractor as provided for in 907 KAR 17:010. A Member may request a State Fair Hearing for an Action taken by the Contractor that denies or limits an authorization of a requested service or reduces, suspends, or terminates a previously authorized service. The standard timeframe for reaching a decision in a State Fair Hearing is found in KRS Chapter 13B. Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member. The contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but not later than 72 hours from the date the Contractor receives notice reversing the determination, if the services were not furnished while the appeal was pending and the State Fair Hearing results in a decision to reverse the Contractor's decision to deny, limit, or delay services. The Contractor shall pay for disputed services received by the Member while the appeal was pending and the State Fair Hearing reverses a decision to deny authorization of the services. The Department shall provide for an expedited State Fair hearing within three (3) days of a request for an appeal that meets the requirements of an expedited appeal after a denial by the Contractor.				
28.9 Provider Grievances and Appeals				
The Contractor shall implement a process to ensure that a Provider shall have the right to file an internal appeal with the Contractor regarding denial of a health care service or	Substantial - Includes file review summary results for Provider Grievances and Provider Appeals	Substantial	Includes file review results for provider grievances and provider appeals.	**Anthem Response:** Anthem retrained the appropriate associates at the time of the onsite,

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**
claim for reimbursement, provider payment or contractual issues. The Contractor shall provide written notification to the Provider regarding a denial. The Department shall provide a standard Provider Grievance Form to be used by the Contractor to initiate its provider grievance process. Appeals received from Providers that are on the Member's behalf for denied services with requisite consent of the Member are deemed Member appeals and not subject to this Section. Contractor shall log Provider appeals. Appeals shall be recorded in a written record and logged with the following details: date, nature of Appeal, identification of the individual filing the Appeal, identification of the individual recording the Appeal, disposition of the Appeal, corrective action required and date resolved. Provider grievances or appeals shall be resolved and the Provider shall receive in writing the resolution within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the Contractor. The Contractor shall ensure that there is no discrimination against a Provider solely on the grounds that the Provider filed an Appeal or is making an informal Grievance. The Contractor shall monitor and evaluate Provider Grievances and Appeals. The Contractor shall submit monthly reports to the Department regarding the number, type and outcomes including final denials of Provider Grievances and Appeals.	Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) <u>Quarterly Desk Audit Results-Provider Grievances</u> Q1 2016–Five provider grievance reported; no trends noted Q2 2016 – No provider grievances reported Q3 2016 –No provider grievances reported. <u>Quarterly Desk Audit Results-Provider Appeals</u> Q1 2016 – Anthem reported 150 provider appeals for medical necessity resolved in Q1 as compared to 96 in Q4 2015. 98% of provider appeals for medical necessity were completed within the required timeframes. Q2 2016 - Anthem indicated 237 provider appeals resolved in Q2 as compared to 150 in the Q1 2016. 98.31% of provider appeals were completed within the required timeframes. Q3 2016 - Anthem reported 236 provider appeals resolved in the		Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results) This requirement is addressed in the Grievance Process: Providers-KY Policy. The MCO provided quarterly reports with tabs for both member and provider grievances and appeals. There are breakouts for dental appeals, as well. All quarterly files were provided and reviewed. **<u>Provider Grievance File Review Results</u>** Four (4) of 7 files reviewed met timeliness requirements. Seven (7) of 7 files reviewed met the file documentation and the notification requirements. Timeliness issues: the MCO identified human error regarding the definition of business versus calendar days. The policy is accurate. The MCO has addressed the issue through training and weekly monitoring, and daily aging report monitored by operations. **<u>Provider Appeal File Review Results</u>** Nine (9) of 10 files reviewed met the	and is monitoring closely to mitigate future timeliness deficiencies.

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**
	quarter as compared to 237 in the 2nd quarter 2016. 99.97% of provider appeals were completed within the required timeframes. The intake process surrounding dental appeals was identified as an area of opportunity as the procedure for DQ notification was not consistently being followed. Medical Necessity Appeals Opportunity for Improvement The MCO is working with their IT developers to identify specific dental appeals to populate on the appeals activity report with a goal of resolution on the Q3 report. Currently there is a corrective action plan in place to remedy the intake process and timeliness of acknowledgment letters as well as routing to the Quality Department for resolution. Two separate audit checkpoints are in place as well as monetary penalties for misroutes. Routing and categorization errors are escalated immediately upon discovery from the Quality Department to the manager of intake for resolution and retraining. During the onsite audit, Anthem did not provide evidence to respond to the		timeliness requirements. Ten (10) of 10 files reviewed met the documentation and the notification requirements. **Recommendation for MCO** The MCO should continue to train and monitor staff to ensure timeliness requirements are addressed.	

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**
	1st Qtr CAP with regard to their work in progress (from their IT developers) to identify specific dental appeals to populate on the appeals activity report. <u>Provider Appeal File Review Results</u> 10/10 Provider Appeal files met all requirements and were resolved within 30 days. There were no extensions in the sample <u>Provider Grievance File Review Results:</u> 2/2 Provider grievance files met all requirements and were resolved within 30 days. There were no extensions in the sample. **<u>Recommendation for Anthem</u>** Anthem should finalize their system upgrade to identify specific dental appeals to populate on the appeals activity report. Anthem should ensure that there is an effective and reliable process in place to identify, resolve and track all provider grievances. **MCO Response:** As Anthem agrees with this finding. As outlined in the Provider 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**
	policy, a process is in place to intake, track, and respond within defined timeframes. As discussed, the provider grievance volume trends low due to providers submitting complaints directly to DMS outside of the health plan grievance process.			
A Provider who has exhausted the Contractor's internal appeal process shall have a right to appeal a final denial, in whole or in part, by the Contractor to an external independent third party in accordance with applicable state laws and regulations. The Contractor shall provide written notification to the Provider of its right to file an appeal. A Provider shall have a right to appeal a final decision by an external independent third party to the Cabinet for Health and Family Services Division of Administrative Hearings for a hearing in accordance with applicable state laws and regulation. If the Provider prevails, in whole or in part, the Contractor shall comply with any Final Order within sixty (60) days unless the Final Order designates a different timeframe.	Full - October 2017 Review Findings This is addressed in the updated policy KY_CMXX_002, Provider Claim Appeals-KY. January 2017 Review Findings Non-Compliant - Although Anthem stated they have completed all the work necessary to implement this requirement by updating letters requiring additional language regarding 3rd party review rights and secured a workflow process to ensure 3rd party requests are handled at Central intake and forwarded to the Health plan queues to work. No evidence was provided to support that this process implemented during the review period. In addition, the MCO's Provider Appeal policy KY_CMXX_002 was not updated to reflect this new requirement. **Recommendation for Anthem** The MCO should update the Provider	Full	This requirement is addressed in the Provider Claim Appeals – KY Policy.	

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
	Appeal policy to include the new Contact language to meet this requirement. **MCO Response**: Agree with findings. The Been updated to reflect the 3rd party Appeal right implemented 12/1/16 and was submitted to DMS in March 2017. New Requirement			
28.10 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.	Deemed for 2017			
38.8 Grievance and Appeal Reporting Requirements				
The Contractor shall submit to the Department on a quarterly basis the total number of Member Grievances and Appeals and their disposition. The report shall be in a format approved by the Department and shall include at least the following information: A. Number of Grievances and Appeals, including expedited appeal requests; B. Nature of Grievances and Appeals; C. Resolution; D. Timeframe for resolution; and E. QAPI initiatives or administrative changes as a result of analysis of Grievances and Appeals.	Deemed for 2017		Includes review of MCO Reports: #27 Grievance Activity #28 Appeal Activity #29 Grievances and Appeals Narrative (see Quarterly Desk Audit results)	
The Department or its contracted agent may conduct	Deemed for 2017			

Final Findings

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
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.				

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Grievance System
Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	1	0	0
Total Points	33	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		**2.92**		

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

Reviewer Decision:

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

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

Final Findings

Grievance System
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

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

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
35.1 Health Risk Assessment (HRA)				
The Contractor shall have programs and processes in place to address the preventive and chronic physical and behavioral health care needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.	Full - This requirement has been addressed in the revised HRA approved by DMS. The MCO provided a sample of the Adult and Child HRA which includes questions #15 and #19 pertaining to the use of drugs or alcohol, and help with making an appointment with the primary care provider.			
The Contractor shall conduct initial health screening assessments including mental health and substance use disorders screenings, of new Members who have not been enrolled with the Contractor in the prior twelve (12) month period, for the purpose of assessing the Member's health care needs within ninety (90) days of Enrollment. If the Contractor has a reasonable belief a Member is pregnant, the Member shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.	Substantial - Includes HRA file review results This requirement is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY. HRA File Review Results A total of 5 HRAs were completed among 25 files reviewed. 12/25 files did not indicate three attempts to reach the member. 25/25 files did not contain the welcome letter to the members. Refusals and pregnant members were not clearly identifiable in the files. **Recommendation for Anthem** The MCO should ensure refusals are clearly indicated in the files. The MCO should ensure the files identify if a member is pregnant and screened within 30 days of enrollment, and if pregnant, referred for appropriate prenatal care.	Substantial	This requirement is addressed in the policy - Health Risk Assessment (HRA) – KY. **File Review Results** Seven (7) of 25 files reviewed had completed HRAs. All seven (7) were completed within the time required. Eighteen (18) of 25 files reviewed did not have completed HRAs. Sixteen (16) of these 18 files showed reasonable effort to contact the member. The two (2) files that did not meet requirements were investigated by the MCO and found to have triggered a non-valid eligibility error that caused the team not to follow up with the member. The MCO is looking into system issues and remediating. **Recommendation for MCO** The MCO should remediate the system error	**Anthem Response-** Anthem respectfully clarifies this was not a "non-valid eligibility error" as stated in the File Review Results. A document titled "HRA file transfer error – Case Listing #10 & #13" was supplied during the onsite visit on 10/17/18, as well as uploaded on 10/17/18 stating the issue was determined to be an "electronic transfer error" on the original input file and included a list of defined possible transfer error types. Anthem will continue to work with IT to evaluate reasons that eligible member data is not transferred successfully when identified. In addition, Anthem will start monthly internal audits by pulling 30 random files and completing an audit of the first 12 to identify any electronic

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	MCO Response: Anthem respectfully disagrees with the recommendation "the MCO should ensure that refusals are clearly indicated in the files". The spreadsheet provided during the interview showed the result of each call attempt for each member. The health plan explained that we will leave up to three messages for a member. We will also try up to six times to reach a member if there is a busy signal or no one answers. If a member hung up, this is a refusal and we will not try to reach them again. When we leave messages for members, we leave a phone number that they can call us back. The health plan respectfully disagrees that we did not ensure that the files were identified as a pregnant member and screened within 30 days of enrollment, and if pregnant, referred for appropriate prenatal care. In the case listings, a pregnant member was identified. During the interview process, the health plan explained that the file came over without a phone number from the Department upon her initial enrollment of 7/12/16 however, the member completed a mailed HRA on 9/23/16. The correct phone number did not come over on the file until 10/5 after she delivered and she was enrolled in the postpartum and well child at that time. **Final Review Determination** No change in the final determination. Based on		and institute a monitoring protocol to ensure that all new enrollees either complete their HRA or receive the prescribed level of outreach to solicit the HRA. **Final Review Determination** IPRO appreciates Anthem's response and the efforts they will put forth in this area. No change to final determination.	transfer errors and confirm all outreach attempts were completed.

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 documentation provided during the onsite it was not clearly indicated on the spreadsheet which members refused/hung up and those members who were pregnant.			
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire which includes the survey instrument for both substance use and mental health disorders. Reasonable effort is defined as at least three attempts to contact the Member with at least one of those attempts by phone. The three attempts by the Contractor may not be within the same day.	Full - Includes HRA file review results This requirement is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY. <u>HRA File Review Results:</u> A total of 5 HRAs were completed among 25 files reviewed. 12/25 files did not indicate three attempts to reach the member. 25/25 files did not contain the welcome letter to the members. **MCO Response:** Anthem respectfully disagrees with the recommendations. During the interview, the Director had a folder prepared with documentation that demonstrated the welcome letters. The interviewer requested that rather than go through it Anthem should upload the document. A spreadsheet was uploaded to the sharepoint site during the site visit which contained the date of the HRA mailing and the date the new member welcome packet data was sent to the member. The document name uploaded in the IPRO folder Documents Submitted during Onsite: HRA File pull Members' HRA mailing date and		Includes HRA file review results.	

Final Findings

Health Risk Assessment (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	HRA welcome packet date. **<u>Final Review Determination</u>** Based on Anthem's response for this requirement the final determination is changed to full.			
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/or any other health or community services.	Full - Includes HRA file review results This requirement is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY and the submitted KY HRA Paper Screening Tools, which include demographic and current health and behavioral health status. An algorithm to identify triggers for the need for care management, disease management and other health services based on HRA responses is addressed in Policy and Procedure Health Risk Assessment (HRA)-KY. <u>HRA file review results:</u> All completed HRA files (5/5) included required domains of inquiry. 0/5 completed HRA files indicated pregnancy. In 0/5 completed HRA files, there was no evidence that identified health issues (tobacco, alcohol/substance).		Includes HRA file review results.	
The Contractor shall use appropriate healthcare professionals in the assessment process.				
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Members	Full - This requirement was addressed in the revised Policy and Procedure Health Risk Assessment (HRA) on page 2. The policy indicates "A question on the HRA asks if 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**
potential risk, if any, for specific diseases or conditions, including substance use and mental health disorders.	member would like assistance with making their initial appointment with their PCP". The MCO provided a sample of the Adult and Child HRA which includes question #19 "May we help you make an appointment with your primary care provider (PCP)?" Name and contact number of PCP:			
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.	Deemed in 2017		Includes review of MCO Report #79 Health Risk Assessments (see Quarterly Desk Audit results).	
The Contractor shall, upon request, share with the Department or another MCO, if the Member is assigned to the MCO, the result of any identification and assessment of the Member's needs to prevent duplication.	Deemed in 2017			
The Contractor shall be responsible for the management and continuity of health care for all Members.	Deemed in 2017			
The Contractor shall utilize a common HRA if one is designated by the Department.	Deemed in 2017			

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Health Risk Assessment

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings

Health Risk Assessment
Suggested Evidence

Documents

Policies/procedures for:

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

File Review

File review of a sample of cases selected by the EQRO

Reports

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

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.2 Provider Credentialing and Recredentialing				
The Contractor shall conduct Credentialing and Recredentialing in compliance with National Committee for Quality Assurance standards (NCQA), 907 KAR 1:672 or other applicable state regulations and federal law. The Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat Members. Detailed documentation and scope of the Credentialing and Recredentialing process is contained in **Appendix J. "Credentialing Process."** The Contractor shall complete the Credentialing or Recredentialing of a Provider within ninety (90) calendar days of receipt of all relative information from the Provider or within forty-five (45) days if the Provider is providing substance use disorder services.. The status of pending requests for credentialing or recredentialing shall be submitted as required in **Appendix J.** "**Credentialing Process.**" Unless prohibited by NCQA standards, if the Contractor allows the Provider to provide covered services to its Members before the credentialing or recredentialing process is completed and the Provider is credentialed, the Contractor shall allow the Provider to be paid for the period from the date of its application for credentials to completion of the credentialing or recredentialing process. If the Contractor accepts the Medicaid enrollment application on behalf of the provider, the Contractor will use the format provided in **Appendix J. "Credentialing Process"** to transmit the listed provider	Deemed in 2017 New Requirement	Full	This requirement is addressed in the KY State Specific Cred Policy 042818, Credentialing Policy 5- Initial Application, Credentialing Policy 9- Re-credentialing, and Credentialing Policy 12 Ongoing Sanction Monitoring. The MCO provided committee minutes in support of ongoing implementation.	

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enrollment data elements to the Department. A Provider Enrollment Coversheet will be generated per provider. The Provider Enrollment Coversheet will be submitted electronically to the Department. The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate action.				
Appendix J				
This documentation shall include, but not be limited to:				
defining the scope of providers covered,	Deemed in 2017			
the criteria and the primary source verification of information used to meet the criteria,	Deemed in 2017			
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.	Deemed in 2017			
The Contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.	Deemed in 2017			
Those providers accountable to a formal governing body for review of credentials shall include physicians,	Deemed in 2017			

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dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.				
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.	Deemed in 2017			
The Contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The Contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.	Deemed in 2017			
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.	Deemed in 2017			
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such	Deemed in 2017			

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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**
additional information as may be specified by the Department.				
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 205.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.	Deemed in 2017			
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;	Deemed in 2017			
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;	Deemed in 2017			
C. A review of the credentialing policies and procedures by the formal body;	Deemed in 2017			
D. A credentialing committee which makes recommendations regarding credentialing;	Deemed in 2017			
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;	Deemed in 2017			
F. Written procedures for the termination or	Deemed in 2017			

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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**
suspension of Providers; and				
G. Written procedures for, and implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.	Deemed in 2017			
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:	Deemed in 2017		Includes credentialing file review summary results.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.	Deemed in 2017			
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;	Deemed in 2017			
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not board certified.	Deemed in 2017			
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;	Deemed in 2017			
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;	Deemed in 2017			
F. Previous five (5) years work history;	Deemed in 2017			
G. Professional liability claims history;	Deemed in 2017			

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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;	Deemed in 2017			
I. Current, adequate malpractice insurance, as verified through attestation;	Deemed in 2017			
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;	Deemed in 2017			
K. Documentation of curtailment or suspension of medical staff privileges;	Deemed in 2017			
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;	Deemed in 2017			
M. Documentation of censure by the State or County professional association;	Deemed in 2017			
N. Most recent information available from the National Practitioner Data Bank;	Deemed in 2017			
O. Health and Human Services Office of Inspector General (HHS OIG); and	Deemed in 2017			
P. System for Award Management (SAM).	Deemed in 2017			
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;	Deemed in 2017			

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B. Lack of present illegal drug use;	Deemed in 2017			
C. History of loss of license and felony convictions;	Deemed in 2017			
D. History of loss or limitation of privileges or disciplinary activity;	Deemed in 2017			
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and	Deemed in 2017			
F. Applicants attest to correctness and completeness of the application	Deemed in 2017			
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;	Deemed in 2017			
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and	Deemed in 2017			
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.	Deemed in 2017			
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and as required by law.	Deemed in 2017			
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.	Deemed in 2017			

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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.	Full - The Provider Recruitment and Retention Policy addresses the requirement that the plan conduct an orientation for providers which includes an evaluation of the medical record documentation and keeping practices. The Medical Record Audit Policy details the process used by the plan to evaluate the documentation of its providers, record the results, and provide recommendations. Anthem provided their Medical Record Documentation Review Log which is the audit tool the plan uses to monitor the data collected at each site. The Provider Audit Notification Letter and the Chart Audit Letter Fail were submitted as evidence of the plan's communication with the provider both before and after the site visits.			
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:	Deemed in 2017		Includes recredentialing file review summary results.	
A. A current license to practice;	Deemed in 2017			

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B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;	Deemed in 2017			
C. A valid DEA number, if applicable;	Deemed in 2017			
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;	Deemed in 2017			
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and	Deemed in 2017			
F. A current signed attestation statement by the applicant regarding:	Deemed in 2017			
1. The ability to perform the essential functions of the position, with or without accommodation;	Deemed in 2017			
2. The lack of current illegal drug use;	Deemed in 2017			
3. A history of loss, limitation of privileges or any disciplinary action;	Deemed in 2017			
4. Current malpractice insurance;	Deemed in 2017			
5. Health and Human Services Office of Inspector General (HHS OIG);	Deemed in 2017			
6. System for Award Management (SAM).	Deemed in 2017			
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on				

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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**
practitioner from :				
A. The national practitioner data bank;	Deemed in 2017			
B. Medicare and Medicaid;	Deemed in 2017			
C. State boards of practice, as applicable; and	Deemed in 2017			
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.	Deemed in 2017			
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.	Deemed in 2017			
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulatory bodies, including the Department, 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.	Deemed in 2017			
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.	Deemed in 2017			
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department,	Full - The Provider Terminations – Primary Care Provider, Specialist and			

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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**
serious quality deficiencies that could result in a practitioner's suspension or termination.	Hospital Policy addresses notification to the Department when the Contractor terminates a provider from its network. The requirement that the plan notify the Department of serious quality deficiencies that could result in suspension or termination is addressed in the Provider Recruitment and Retention Policy on page 4.			
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.	Deemed in 2017			
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm	Deemed in 2017			
29.1 Network Providers to be Enrolled				
The Contractor shall maintain, by written agreements, a network of Providers that consider the geographic location of Providers and its Members, the distance, travel time, the means of transportation ordinarily used by its Members, whether the location provides physical access for its Members with disabilities, and considers the numbers of network Providers who are not accepting new Medicaid patients.	Substantial - The requirement that the plan comply with the 'any willing provider statute' is addressed on page 2 of the Provider Recruitment and Retention Policy-KY. Substantial - The requirement that the plan enroll at least one FQHC into its network for each region is addressed on page 4 of	Full	This requirement is addressed in the Provider Recruitment and Retention-KY Policy.	

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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) and one (1) Rural Health Clinic into its network for each region where available and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, psychiatrists advanced practice registered nurses, physician assistants, free-standing birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, speech language pathologists, physical therapists, occupational therapists, private duty nursing agencies, pharmacies, durable medical 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	the Provider Recruitment and Retention Policy. However, the language "and one (1) Rural Health Clinic" is missing from the policy. **Recommendation for Anthem** Anthem should update the policy to include all of the State required language. **MCO Response:** Anthem agrees with this recommendation. The updated Provider Recruitment & Retention Policy-KY was provided to IPRO at the time of the audit.			

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

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State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Department will continue to enroll hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, FQHC, RHC and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the CASPER/QIES file formally known as OSCAR provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.	Deemed in 2017			
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.	Deemed in 2017			
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.	Deemed in 2017			
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who	Deemed in 2017			

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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**
are willing to meet the terms and conditions for participation established by the Contractor.				
29.2 Out-of-Network Providers				
The Department will provide the Contractor with an expedited enrollment process to assign provider numbers for providers not already enrolled in Medicaid for emergency situations only.	Deemed in 2017			
29.3 Contractor's Provider Network				
All providers in the Contractor's network shall be enrolled in the Kentucky Medicaid Program. The Contractor may enroll providers in their network who do not provide services to the fee-for-service population. Providers shall meet the credentialing standards described in the Provider Credentialing and Re-Credentialing section of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll or continue participation in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney	Deemed in 2017	Minimal	The MCO cited the following policies for fulfillment of this requirement: Provider Recruitment and Retention and PCP Termination and Member Notification and Reassignment. However, these policies, along with the Initial Credential, Recredentialing, and Kentucky-Specific Credentialing and Credentialing Program Summary do not include all required language for this requirement. The MCO's Credentialing Program Summary meets the following requirements: 1. Providers must be Medicaid enrolled 2. Credentialing standards 3. Sanctions However, the following requirements are not addressed: 1. Kentucky administrative regulations 2. Money owed to Medicaid 3. Active fraud investigation	**Anthem Response:** Anthem respectfully requests reconsideration of this element. Anthem provided the updated Policy titled "REDLINE Provider Recruitment and Retention-KY" at the time of the onsite on 10/17/2018. This document included all the required language provided in the element. Once approved, the Policy will follow Anthem's policy format, and the redlined document will be finalized.

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General has an active fraud investigation involving the Provider or the Provider otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.			Furthermore, this document is not in the MCO's policy format. **Recommendation for MCO** The MCO should update their policies to incorporate the required language. **Final Review Determination** This updated policy was updated after the contract review period and is in draft format. It can be used for the next compliance review once approved. No change in final determination.	
29.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent. The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.	Deemed in 2017	Full	This requirement is addressed in the DMS Provider Network File dated 6/22/2018.	

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29.5 Enrolling New Providers and Providers not Participating in Medicaid				
A provider is not required to participate in the Kentucky Medicaid Fee-for-Service Program as a condition of participation with the Contractor's Network but must be enrolled in the Kentucky Medicaid Program. If a potential Provider has not had a Medicaid number assigned, the provider shall apply for enrollment with the Department and meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. When the Contractor has submitted the required data in the transmission of the provider file indicating inclusion in the Contractor's Network, the Department will enter the provider number on the master provider file and the transmitted data will be loaded to the provider file. The Contractor will receive a report within two weeks of transactions being accepted, suspended or denied. All documentation regarding a provider's qualifications and services provided shall be available for review by the Department or its agents at the Contractor's offices during business hours upon reasonable advance notice.	Full - This requirement is addressed on page 2 of the Provider Recruitment and Retention Policy.			
29.6 Termination of Network Providers				
A. The Contractor shall terminate from participation any Provider who (i) engages in an activity that violates any law or regulation and results in	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	

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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.				
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid program within three (3) business days via e-mail. The Contractor shall terminate the Provider effective upon receipt of notice by the Department.	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	
The Contractor shall notify the Department of termination from Contractor's network taken against a Provider under this subsection within three (3) business days via email. The Contractor shall indicate in its notice to the Department the reason or reasons for the termination.	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminated Provider within the previous six months. Such notice shall be mailed within fifteen (15) days of the action taken if it is a PCP and within thirty (30) days for any other Provider.	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	
B. In the event a Provider terminates participation with the Contractor, the Contractor shall notify the Department of such termination by Provider within five business days via email. In addition, the Contractor will provide all terminations monthly, via	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	

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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 Termination Report. The Contractor shall indicate in its notice to the Department the reason or reasons for which the PCP ceases participation.				
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) thirty (30) days prior to the effective date of the termination or (ii) within fifteen (15) days of receiving notice.	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy	
C. The Contractor may terminate from participation any Provider who materially breaches the Provider Agreement with Contractor and fails to timely and adequately cure such breach in accordance with the terms of the Provider Agreement.	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	
The Contractor shall notify any Member of the Provider's termination provided such Member has received a service from the terminating Provider within the previous six months. Such notice shall be mailed the later of the following: (i) within fifteen (15) days of providing notice or (ii) thirty (30) days prior to the effective date of the termination.	Deemed in 2017	Full	This requirement is addressed in the PCP Termination and Member Notification and Reassignment Service Form Process Policy.	

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Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

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	11	0	1	0
Total Points	33	0	1	0

Overall Compliance Determination:

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

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	Statement does not require a review decision

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

Final Findings

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

Documents

Policies and Procedures for:

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

Credentialing Committee description, membership, meeting agendas and minutes

Reports

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

File Review

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

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
28.3 Primary Care Provider Responsibilities				
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, , FQHC look-alike primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs including for a Member who has a gynecological or obstetrical health care need, a disability, or chronic illness. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist, and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's				

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
policies including but not limited to the following:				
A. Maintaining continuity of the Member's health care;	Deemed for 2017	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;	Deemed for 2017	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;	Deemed for 2017	Full	This requirement is addressed in the provider manual.	
D. Discussing Advance Medical Directives with all Members as appropriate;	Deemed for 2017	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;	Deemed for 2017	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	Deemed for 2017	Full	This requirement is addressed in the provider manual.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers.	Deemed for 2017	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 the hours of service of their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.	Deemed for 2017	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;	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy. Performance of this requirement is tested through access and availability studies.	
(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	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy. Performance of this requirement is tested through access and availability studies.	
(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.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy. Performance of this requirement is tested through access and availability studies.	
B. Unacceptable				
(1) Office phone is only answered during office hours;	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
(2) Office phone is answered after hours by a recording that tells Members to leave a message;	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
(4) Returning after-hours calls outside of thirty (30) minutes.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
29.7 Provider Program Capacity Demonstration				

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 Contractor shall assure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Medicaid Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of medically necessary services.	Deemed for 2017	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.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
Emergency medical and behavioral health services shall be made available and accessible to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available and accessible within 48 hours of request. The Contractor shall provide the following:	Deemed for 2017 New Requirement	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 Member residence in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.	Deemed for 2017	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Policy and in the provider manual. The MCO submitted their GeoAccess reports which demonstrate compliance.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. If either the Contractor or a Provider (including Behavioral Health) requires a referral before making an appointment for specialty care, any such appointment shall be made within thirty (30) days for routine care or forty-eight (48) hours for Urgent Care.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy and in the provider manual. During the onsite interviews Anthem directed us to an additional policy, Access to Health Specialists – KY, which states on page 1 "PCP referrals are not required to see participating specialty providers, unless the member is restricted in the Lock-in Program."	
C. In addition to the above, the Contractor shall include in its network Specialists designated by the Department; and include sufficient pediatric specialists to meet the needs of Members younger than 21 years of age. Access to Specialists shall not exceed sixty (60) miles or sixty (60) minutes. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight (48) hours for urgent care .	Full - Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results) The Access and Availability Policy was updated to address this requirement. The GeoAccess reports display all Specialists, as per IPRO's request, with 100% access for members by miles and minutes. New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the provider manual. GeoAccess reports demonstrate compliance in relation to specialists in general. Onsite discussions raised the issue of differentiating those specialists treating members under 21 years of age. In addition to monthly network access reports provided by DMS, Anthem mentioned that they monitor member complaints related to availability of providers, send people to border states where provider networks are sparse in rural locations, and enter into single case agreements.	
D. Immediate treatment for any Emergency Medical or Behavioral Health Services by a health provider that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
E. Access to Hospital care shall not exceed thirty (30)	Deemed for 2017	Full	Includes review of MCO Report #12A	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
miles or thirty (30) minutes, except in non-urban areas where access may not exceed sixty (60) miles or (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) miles or sixty (60) minutes.			GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Policy and in the provider manual. The MCO submitted their GeoAccess reports which demonstrate compliance.	
F. Access for general dental services shall not exceed 60 miles or 60 minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and 48 hours for urgent care.	Deemed for 2017 New Requirement	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Policy and in the provider manual. The MCO submitted their GeoAccess reports which demonstrate compliance.	
G. Access for general vision, laboratory and radiology services shall not exceed (60) miles or sixty (60) minutes. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty-eight 48 hours for Urgent Care.	Deemed for 2017 New Requirement Full	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Policy and in the provider manual. The MCO submitted their GeoAccess reports which demonstrate compliance.	
H. Access for Pharmacy services shall not exceed Thirty (30) miles or thirty (30) minutes.	Deemed for 2017	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Policy and in the provider manual. The MCO submitted their GeoAccess reports which demonstrate compliance.	
I. In addition to any Community Mental Health Center or	Full - The Access and	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**
Local Health Department which the Contractor has in its network, the Contractor shall include in its network Mental Health and Substance Abuse providers for both adults and children in no fewer number than fifty (50%) percent of the Mental Health and Substance Abuse providers enrolled in the Medicaid program to provide out-patient, intensive out-patient, substance abuse residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services.	Availability Policy was updated to address this requirement. The GeoAccess reports indicates 100% access for Behavioral Health providers for members by miles and minutes. Program Capacity Report to monitor specialist and behavioral health access against Medicaid provider enrollment was moved to production in November 2016. This report eliminated the previous gaps in specialties that included BHSO without Residential Services, BHSO Including Residential Services to all Members, and Behavioral Health Multi-Spec Groups. Anthem provided this report as evidence during the onsite visit.		and Availability Policy.	
J. The Department shall notify the Contractor and all other MCOs on contract with the Department when more than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. The Contractor shall provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives to Members to reduce unnecessary Emergency Room visits so that the	Full - This requirement was addressed in the document Identification and Management of High Emergency Room Utilizers – KY.	Substantial	This requirement is addressed in the Identification and Management of High Emergency Room Utilizers Policy. The cited policy addresses identification of over utilization and remediation. It does not, however, address the specific thresholds listed in the contract language.	**Anthem Response:** Anthem respectfully requests reconsideration. Anthem provided pre-onsite the exact language in the Policy section as stated below in the Identification and Management of High Emergency Room Utilizers Policy: "In addition, DMS will notify Anthem when more

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**
determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. The Contractor and all other MCOs shall provide such alternate sites or incentives based upon the number of their respective members in the Medicaid Region.			The MCO states they do not receive these reports from DMS. This process may be on hold at the time. **Recommendation for MCO** The MCO should incorporate the required language into their policies. **Final Determination** No change in final determination. After review of Anthem's response by IPRO and DMS, Anthem should remove the wording "as deemed required" in the policy Identification and Management of High Emergency Room Utilizers - KY.	than five (5%) percent of Emergency Room visits in a Medicaid Region, in a rolling three (3) month period, are determined to be a non-emergent visit. Anthem will provide sufficient alternate sites for twenty-four (24) hour care and appropriate incentives, as deemed required, to Members to reduce unnecessary Emergency Room visits so that the determination of non-emergent visits are reduced to no more than two (2%) percent in a rolling three (3) month period for that Medicaid Region. Anthem will provide such alternate sites based upon the number of their respective members in the Medicaid Region."
29.8 Additional Network Provider Requirements				
A. The Contractor shall attempt to enroll the following Providers in its network as follows:				
1. Teaching hospitals;	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
2. FQHCs and rural health clinics;	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
3. The Kentucky Commission for Children with Special Health Care Needs; and	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
4. Community Mental Health Centers	Deemed for 2017	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	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.				
B. In consideration of the role that Department for Public Health, which contracts with the local health departments plays in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to the Department of Public Health for local health department services. Such participation agreements shall include, but not be limited to, the following provisions:	Deemed for 2017			
1. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.	Deemed for 2017	Full	This requirement is addressed in the agreement with the Kentucky Department for Public Health.	
2. Provide reimbursement at rates commensurate with those provided under Medicare.	Deemed for 2017	Full	This requirement is addressed in the agreement with the Kentucky Department for Public Health.	
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
C. The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties to assure quality and access to health care services as required for the Quality Improvement program as outlined in Management Information Systems. If the Contractor is unable to contract with the providers listed in this subsection, it shall submit to the Department, for approval,	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.				
29.9 Provider Network Adequacy				
The Contractor shall submit information in accordance with Appendix L that demonstrates that the Contractor has an adequate network that meets the Department's standards in the Provider Program Capacity Demonstration section of this contract. The Contractor shall notify the Department, in writing, of any anticipated network changes that may impact network standards herein.	Deemed for 2017	Full	Includes review of MCO Report #12A GeoAccess Network Reports & Maps (see Quarterly Desk Audit results). This requirement is addressed in the Access and Availability Policy. Quarterly GeoAccess reports and summary reports were provided to demonstrate compliance.	
The Contractor shall update this information to reflect changes in the Contractor's Network monthly.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
29.10 Expansion and/or Changes in the Network				
If at any time, the Contractor or the Department determines that its Contractor Network is not adequate to comply with the access standards specified above for 95% of its Members, the Contractor or Department shall notify the other of this situation and within fifteen (15) business days the Contractor shall submit a corrective action plan to remedy the deficiency. Providers in the Contractor's Network who will not accept Medicaid Members shall not be included in the assessment as to whether the Contractor's Network is adequate to comply with access standards. The corrective action plan shall describe the deficiency in detail, including the geographic location where the problem exists, and identify specific action steps to be taken by the Contractor and time-frames to correct the deficiency.	Deemed for 2017	Full	Includes review of MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results). This requirement is addressed in the Provider Recruitment and Retention Policy. Quarterly reports were submitted and reviewed.	
In addition to expanding the service delivery network to	Deemed for 2017	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**
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.			Recruitment and Retention Policy.	
31.1 Medicaid Covered Services				
The Contractor shall provide Covered Services in an the amount, duration, and scope that is no less than the amount, duration, and scope furnished Medicaid recipients under fee-for-service program; that are reasonably be expected to achieve the purpose for which the services are furnished; enables the Member to achieve age-appropriate growth and development; and enables the Member to attain, maintain, or regain functional capacity. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The contractor may establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members; may place appropriate limits on a service on the basis of criteria applied under the Medicaid State Plan, and applicable regulations, such as medical necessity; and place appropriate limits on a service for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Member's ongoing need for such services and supports, and family planning services	Deemed for 2017 New Requirement	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**
are provided in a manner that protects and enables the Member's freedom to choose the method of family planning.				
The Contractor shall provide, or arrange for the provision of Covered Services to Members in accordance with the state Medicaid plan, state regulations, and policies and procedures applicable to each category of Covered Services. The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix H shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in the State Medicaid Plan, applicable administrative regulations governing Kentucky Medicaid services and individual Medicaid program services manuals incorporated by reference in the administrative regulations.	Deemed for 2017	Full	This requirement is addressed in the provider manual.	
The Contractor may provide, or arrange to provide, services in addition to the services described above, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.	Deemed for 2017	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**
For any Medicaid service provided by the Contractor that requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.	Deemed for 2017	Full	The MCO did not provide policies that address this requirement. **Final Determination** Determination changed to full. The Provider Agreement contains the required language. This supporting document was supplied for Tool #13 – Medical Records. In the future Anthem should include support with the appropriate tool.	**Anthem Response:** Anthem respectfully requests reconsideration of this element. Anthem does not have a policy related to this element, however, this specific language is in our Provider Agreement, previously provided on 9/14/2018. This document is titled EPA Medicaid Attachment and Comp page.pdf" under Section 5.7.1, Page 23.
The Contractor shall not prohibit or restrict a Provider from advising a Member about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.	Deemed for 2017	Full	This requirement is addressed in the provider manual.	
If the Contractor is unable to provide within its network necessary Covered Services, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR 438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	
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.	Deemed for 2017	Full	This requirement is addressed in the provider manual and member handbook.	
33.3 Emergency Care, Urgent Care and Post Stabilization Care				

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**
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within forty-eight (48) hours of request. Urgent Care means care for a condition that is not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c). The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. An Emergency Medical Services Provider shall have a minimum of ten (10) calendar days to notify the Contractor of the Member's screening and treatment before refusing to cover the emergency services based on a failure to notify. A Member who has an emergency medical condition shall not be liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition. The Contractor is responsible for coverage and payment of services until the attending Provider determines that the Member is sufficiently stabilized for transfer or discharge.	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Emergency Services – Core Process.	
33.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in compliance with 42 CFR 438.114.	Deemed for 2017	Full	This requirement is addressed in the provider manual and member handbook.	
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.	Deemed for 2017	Full	The MCO did not provide policies that address this requirement. **Final Determination** Determination changed to full. The required	**Anthem Response:** Anthem respectfully requests reconsideration of this element. This specific language is in our Policy titled, "Emergency Services – Core Process Policy." This Policy was previously provided on 9/14/2018.

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			wording is contained in Anthem's policy - Emergency Services – Core Process	This specific language is located on Page 15.
31.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in this contract. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.	Deemed for 2017	Full	This requirement is addressed in the Provider Recruitment and Retention Policy.	
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:	Deemed for 2017			
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;	Deemed for 2017	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;	Deemed for 2017	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;	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	
D. Maternity care for Members under 18 years of age;	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Immunizations to Members under 21 years of age;	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	
F. Sexually transmitted disease screening, evaluation and treatment;	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	
G. Tuberculosis screening, evaluation and treatment;	Deemed for 2017	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;	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	
I. Chiropractic services;		Full	This requirement is addressed in the Access to Health Specialists Policy.	
J. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, allow members to directly access a specialist as appropriate for the Member's condition and identified needs; and	New Requirement	Full	This requirement is addressed in the Access to Health Specialists Policy.	
K. Women's health specialists.	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	
33.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix H to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure access to any qualified provider of Family Planning Services without requiring a referral from the PCP.	Deemed for 2017	Full	This requirement is addressed in the Access to Health Specialists Policy.	
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal	Deemed for 2017	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**
and state laws and judicial opinions for Members less than eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.				
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.	Deemed for 2017	Full	This requirement is addressed in the Access and Availability Policy.	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	67	1	0	0
Total Points	201	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		**2.99**		

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

Reviewer Decision:

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

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

Final Findings

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

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

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

Final Findings

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

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
21.0 Utilization Management				
21.1 Medical Necessity				
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and clinical appropriateness, and that monitors and evaluates on an ongoing basis the appropriateness of care and services for physical and behavioral health.	Deemed for 2017	Full	The MCO's UM program purpose is outlined on page 4 of the 2018 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.	Deemed for 2017	Full	The 2018 UM Program Description is a written description of the UM program structure and offers information about authority and accountability for all activities, including delegated activities.	
The description shall include the scope of the program;	Deemed for 2017	Full	The scope of the program is addressed on page 6 of the 2018 UM Program Description.	
the processes and information sources used to determine service coverage;	Deemed for 2017	Full	This requirement is addressed in the 2018 UM Program Description.	
clinical necessity, appropriateness and effectiveness;	Deemed for 2017	Full	This requirement is addressed in the 2018 UM Program Description on page 12 under Criteria Selection.	
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;	Deemed for 2017	Full	This requirement is addressed in the 2018 UM Program Description.	
processes to review, approve, and deny services as needed, particularly but not limited to the EPSDT program.	Deemed for 2017	Full	This requirement is addressed in the 2018 UM Program Description in the section addressing medical necessity.	
The UM program shall be evaluated annually,	Deemed for 2017	Full	The Medical Policy and Technical Committee	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
including an evaluation of clinical and service outcomes.			review criteria and guidelines on a yearly basis.	
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director, the Behavioral Health Director, or the Medicaid Commissioner.	Deemed for 2017	Full	This requirement was addressed onsite by the MCO. If there is a change in the UM program, the Medical Operations Committee (MOC), whose organizational structure is discussed within the UM Program Description, will review and approve the program.	
21.2 National Standards for Medical Necessity Review				
The Contractor shall adopt Interqual for Medical Necessity, except that the Contractor shall utilize the American Society of Addiction Medicine (ASAM) for substance use. If Interqual does not cover a behavioral health service, the Contractor shall adopt the following standardized tools for medical necessity determinations - for adults: Level of Care Utilization System (LOCUS); for children: Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS); for young children: Early Childhood Service Intensity Instrument (ECSII). If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the Contractor shall submit its proposed medical necessity criteria to the Department for approval, except that submissions involving medical necessity criteria will not be deemed approved after thirty (30) days. The Department may also, at its discretion, require the use of other criteria it creates or identifies for services or populations not	Substantial - The requirement is addressed by policy Clinical Criteria for Utilization Management Decisions – Core Process, Definition pages 1-3 and Exceptions page 10-11. Language regarding submission of proposed medical necessity criteria to the Department (in the event required criteria are not available for a specific service) was updated in policy Clinical Criteria for Utilization Management Decisions – Core Process, page 11. However, the policy was not approved by the Committee until 1/4/17 (after the review period). **Recommendation for Anthem** Anthem should ensure revised contract requirements are updated	Full	The UM Program Description addresses the language of adoption of various standards for medical necessity determinations on page 7. The new contract language is also addressed in Clinical Criteria for UM Decision-Core Process. The MCO submitted approval from the state for the adoption of the AIMs guidelines for determining medical necessity criteria.	

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**
otherwise covered by the named criteria in the above paragraph. The Contractor will be given ninety (90) days to implement criteria the Department may otherwise require.	timely in policies and procedures. **MCO Response:** Anthem agrees with this finding. New Requirement			
The Contractor shall have in place mechanisms to check the consistency of application of review criteria.	Deemed for 2017	Full	This requirement is addressed in the UM Program Description section on Inter-Rater Reliability and the inter-rater reliability 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.	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in the UM Program Description. **File Review Results** Ten (10) out of 10 files met this requirement.	
The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in the UM Program Description in the description of the organizational structure and also in Health Care Management Denial – Core Process. **File Review Results** Ten (10) out of 10 files met this requirement.	
The clinical reason for the denial, in whole or in part, specific to the Member shall be cited.	Full - Includes UM file review results The requirement is addressed by the policy Health Care Management Denial – Core Process, pages 29-30.	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. The Medical Necessity Denial Letter also serves 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**
	Template Inpatient, Outpatient, and Pharmacy denial letters contain a "Rationale for Denial" field; Inpatient and Outpatient letters contain an additional "Specific Criteria" field. UM File Review Results - Random 10/10 random UM files appropriately provided a clinical reason for the denial.		evidence of compliance with this requirement. **File Review Results** Ten (10) out of 10 files met this requirement.	
Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.	Deemed for 2017	Full	This requirement is addressed on page 21 of the UM Program Description and on page 15 of UM Core Process.	
The Medical Necessity review process shall be completed within two (2) business days of receiving the request and shall include a provision for expedited reviews in urgent decisions. Post-service review requests shall be completed within fourteen (14) days or, if the Member or the Provider requests an extension or the Contractor justifies a need for additional information and how the extension is in the Member's interest, may extend up to an additional fourteen (14) days.	Deemed for 2017	Full	Includes UM file review results. This language and meaning is addressed in Healthcare Management Denial Process and in the UM Program Description on page 21. **File Review Results** Ten (10) out of 10 files did not require an extension.	
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.	Deemed for 2017	Full	This requirement is addressed in the Governance of Utilization Management Practice Policy and UM Program Description.	
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	Deemed for 2017	Full	This requirement is addressed in the UM Program Description, UM Services section, and in the UM – Medicaid Delegation and Oversight Policy.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
mechanism to ensure consistent application of review criteria for authorization decisions.				
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within three (3) working days of providing notification of a decision if the initial decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.	Deemed for 2017	Full	This requirement is addressed in the UM Program Description on page 20.	
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.	Deemed for 2017	Full	This requirement is addressed in Continuity of Care – Core Process.	
E. The Contractor shall have written policies to ensure the coordination of services: 1. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; 2. With the services the Member receives from any other MCO; 3. With the services the member receives in FFS; and 4. With the services the Member receives from community and social support providers.	New Requirement	Non-Compliance	This requirement was not included in any policy during the audit time frame. However, it was included in the Continuation of Care Policy after June 2018.	**Anthem Response-** Anthem agrees with the finding that the language was finalized in the Continuation of Care - Core Process policy on 7/26/18; after the audit timeframe; as you noted the finalized policy was supplied.
F. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.	Deemed for 2017	Full	This requirement is addressed in the UM Program Description on page 32, where the reporting of UM activities to QM activities for analysis of variance are described.	
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208,	Deemed for 2017	Full	This requirement is addressed in the UM Program Description on page 6.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.				
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.	Deemed for 2017	Full	This requirement is addressed in the UM Program Description and Over Under Utilization Services Policy. Onsite, it was discussed that if there is a trend in over-utilization, staff will take a deeper dive to address specifics from a case management perspective. UM staff is responsible for reporting and receives assistance from the QM team. UM staff also gets assistance from finance and corporate services. As for vendors, the MCO's Vendor Management Oversight Committee gets notified about any over- or under-utilization. The findings are reported to the Internal Quality Committee.	
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.	Deemed for 2017	Full	This requirement is addressed in the UM Program Description.	
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.	Deemed for 2017	Full	The MCO is in compliance with this requirement as evidenced by their participation in CAHPS.	
The UM program will be evaluated by the Department on an annual basis.	Deemed for 2017	Full	Includes review of MCO Report #59 Prior Authorizations (see Quarterly Desk Audit	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			results). This item is fulfilled by the MCO's Report #59 for the audit time frame.	
21.3 Adverse Benefit Determination Related to Requests for Services and Coverage Denials				
The Contractor shall provide the Member written notice that meets the language and formatting requirements for Member materials, of any adverse adverse benefit determination (not just service authorization actions) within the timeframes for each type of adverse benefit determination pursuant to 42 CFR 438.210(c). The notice must explain:	Deemed for 2017	Full	This requirement is addressed in Health Care Management Denial – Core Process.	
A. The adverse benefit determination the Contractor has taken or intends to take;	Deemed for 2017	Full	Includes UM file review results. The requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Ten (10) out of 10 files met this requirement.	
B. The reasons for the adverse benefit determination in clear, non-technical language that is understandable by a layperson;	Full - Includes UM file review results The requirement is addressed by the policy Health Care Management Denial – Core Process, page 29. UM File Review Results - Random 10/10 random UM files provided reasons for the action in clear, non-technical language that is understandable by a layperson.	Full	Includes UM file review results. The requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Ten (10) out of 10 files met this requirement.	

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**
C. The right to be provided upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Member's adverse benefit determination, including medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	New Requirement	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Ten (10) out of 10 files met this requirement.	
D. Specific and detailed information as to why the service did not meet medical necessity, if the action related to a denial, in whole or in part, of a service is due to a lack of medical necessity;	New Requirement	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Ten (10) out of 10 files met this requirement.	
E. The federal or state regulation supporting the action, if applicable;	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Ten (10) out of 10 files met this requirement.	
F. The Member's right to appeal including information on exhausting the Contractor's one level of appeal as required by 42 CFR 438.402(b);	Deemed for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
G. The Member's right to request a State hearing	Deemed for 2017	Full	Includes UM file review results.	

Final Findings

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
after receiving notice that the adverse benefit determination is upheld;	New Requirement		This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
H. Procedures for exercising Member's rights to Appeal or file a Grievance;	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
I. Circumstances under which expedited resolution is available and how to request it;	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
J. The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in Health Care Management 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**
required to pay the costs of these services.			**File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
K. Be available in English, Spanish, and each non-English language;	Deemed for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
L. Be available in alternative formats for persons with special needs; and	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement. One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
M. Be easily understood in language and format.	Deemed for 2017	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial – Core Process. **File Review Results** Nine (9) out of 10 files met this requirement.	

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**
			One (1) out of 10 files was not applicable, as it was a provider denial and the letter did not go to the member.	
The Contractor must give notice at least: A. Ten (10) days before the date of an adverse Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to five (5) days if Member Fraud or Abuse has been determined.	Deemed for 2017	Non-Compliance	This requirement was not addressed the Health Care Management Policy or any other policy for the audit timeframe, but the MCO did include the contract language in a revised draft version of the policy after the audit timeframe	**Anthem Response-** Anthem agrees with the finding that the Health Care Management Denial Core Process KY policy language was finalized on 9/11/18, after the audit timeframe; as you noted the finalized policy was supplied to the onsite reviewers during the onsite visit on 10/16/18.
B. The Contractor must give notice by the date of the adverse Action for the following:	Deemed for 2017			
1. In the death of a Member;	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
3. The Member's admission to an institution where he is ineligible for further services;	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
4. The Member's address is unknown and mail directed to him has no forwarding address;	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
5. The Member has been accepted for Medicaid services by another local jurisdiction;	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
6. The Member's physician prescribes the change	Deemed for 2017	Full	This requirement is addressed in Health	

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**
in the level of medical care;			Management Denial Core Process on page 12.	
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
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.	Deemed for 2017	Full	This requirement is addressed in Health Management Denial Core Process on page 12.	
C. The Contractor must give notice on the date of the adverse Action when the Action is a denial of payment.	Deemed for 2017	Full	This requirement is addressed in the 2018 UM Program Description on page 20.	
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of 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.	Deemed for 2017	Full	This requirement is addressed in Health Care Management Denial Core Process on page 9.	
If the Contractor extends the timeframe for an appeal or expedited appeal, and the extension was not at the request of the enrollee, the Contractor must make reasonable efforts to give the Member prompt oral notice of the delay; give the Member	Deemed for 2017 New Requirement	Full	Includes UM file review results. This requirement is addressed in Health Care Management Denial Core Process on page 9.	

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**
written notice within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.			This language is also addressed in the Member Appeals Policy. **File Review Results** Ten (10) out of 10 files did not have evidence of an extension.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) business days after receipt of the request for service.	Deemed for 2017	Full	This requirement is addressed in Health Care Management Denial Core Process on pages 9–10.	
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse benefit determination.	Deemed for 2017	Full	This requirement is addressed in Health Care Management Denial Core Process on pages 9–10.	
21.4 Prior Authorizations				
The Department shall provide a common Prior Authorization Form for all Contractors to utilize for a Provider to initiate its prior authorization process. The Contractor shall give the Provider the option to use the common form or the Contractor specific form.	Deemed for 2017			

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield

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	53	0	0	2
Total Points	159	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		**2.89**		

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

Reviewer Decision:

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

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

Final Findings

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

Documents

Policies/procedures for:

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

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

Reports

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

File Review

Sample of UM files selected by EQRO

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross 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**
37.0 Program Integrity				
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements. The Contractor shall have a sufficient number of investigators as is necessary to detect fraud, waste and abuse.	Deemed for 2017	Full	This requirement is addressed in the Anthem Special Investigations Unit (SIU) Antifraud Plan for Kentucky and in the 2018 Anthem Program Integrity Plan for Medicaid.	
37.1 Program Integrity Plan	New Heading			
The Contractor shall develop in accordance with Appendix N, a Program Integrity plan for the Commonwealth of Kentucky of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. If the Department changes its program integrity activities, the Contractor shall have up to three (3) months to provide a new or revised program. This plan shall include, at a minimum:	Deemed for 2017	Full	This requirement is addressed in the Anthem SIU Antifraud Plan for Kentucky and in the 2018 Anthem Program Integrity Plan for Medicaid.	
A. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the contract as well as all federal and state requirements and standards;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Common Frequently Asked Questions (FAQ) Section on page A6.	
B. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Common FAQ Section on page A6.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements under this Contract;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan's Common FAQ Section on page A6.	
D. Effective training and education for the Contractor's Compliance Officer, senior management, employees, subcontractors, providers and enrollees for federal and state standards and requirements under the contract including; 1.Training and education regarding fraud, waste, and abuse; and 2 Detailed information about the False Claims Act (FCA), rights of employees to be protected as whistleblowers, and other federal and state laws described in Section 1902 of the Act (42 USC 1396a(a)(68));	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Common FAQ Section. It is also referenced in the Anthem Ethics, Compliance and Privacy Plan 2018 – Medicaid Addendum.	
E. Effective lines of communication between the Compliance Officer and the contractor's employees;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Common FAQ Section on page A6.	
F. Enforcement of standards through written and publicized disciplinary guidelines;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Common FAQ Section. It is also referenced in the Anthem Ethics, Compliance and Privacy Plan 2018 – Medicaid Addendum.	
F. Provision for internal monitoring and auditing of the member and provider;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Common FAQ Section on page A7.	
G. Written procedures and an operational system that include but are not limited to the following:	Deemed for 2017			

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
1. Routine internal monitoring and auditing of member, provider and compliance risks by dedicated staff for the Contractor and any Subcontractor;	New Requirement	Full	This requirement is addressed in the Anthem Ethics, Compliance and Privacy Plan 2018 on page 14.	
2. Prompt investigation, response and development of corrective action initiatives to compliance risks or issues as they are raised or identified in the course of self-evaluation or audit, including coordination with law enforcement agencies for suspected criminal acts to reduce potential recurrence and ensure ongoing compliance under the contract;	New Requirement	Full	This requirement is addressed in the Anthem Ethics, Compliance and Privacy Plan 2018 – Medicaid Addendum on page 12.	
3. Provision for immediate notification to the Department's Program Quality & Outcomes Division Director and Program Integrity Division Director should any employee of the Contractor, Subcontractors or agents seek protection under the False Claims Act;	New Requirement	Full	This requirement is addressed in the 2018 Anthem Ethics and Compliance Plan on page 12.	
4. Provision for prompt reporting to the Department of all overpayments identified or recovered, specifying the overpayments due to potential fraud, in a manner as determined by the Department;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A7.	
5. Prompt referral of any potential fraud, waste or abuse that the Contractor identifies to the Department's program integrity unit or any potential fraud directly to the state Medicaid Fraud Control Unit in the form of an investigative report or in another manner as prescribed by the Department;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A8.	
6. Provision for network providers to report and return to the Contractor any overpayment within sixty (60) calendar days of identification and to notify Contractor in writing of the reason for the overpayment;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A9–A10.	

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**
7. Suspension and escrow of payments to a network provider for which the Department has notified the Contractor that there is a credible allegation of fraud in accordance with 42 CFR 455.23 and report payment suspension information quarterly in a manner determined by the Department;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A9–A10.	
8. Prompt notification to the Department when it receives information about a change in a Member's circumstances that may affect the Member's eligibility including changes in the Member's residence or the death of the Member;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A7.	
9. Notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A8–A9.	
10. Method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers have been delivered to Members and the application of such verification processes on a regular basis;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A8.	
11. Ensure all of Contractor's network providers are enrolled with the Department consistent with the provider disclosure, screening and enrollment requirements of 42 CFR 455;	New Requirement	Full	This requirement is addressed in Provider Recruitment and Retention.	
12. An accounts receivable process to collect outstanding debt from enrollees or providers and provide monthly reports of activities and collections to the Department in a manner determined by the Department;	New Requirement	Full	The MCO sends overpayment reports every month to DMS for approval, and then sends notification for the provider to address or rebut within 30 days and make appropriate plans for the payment process remediation.	

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**
			For providers who fail to comply, the MCO will utilize a collections agency vendor to assist in recouping the money. A sample overpayment letter was provided during the onsite audit.	
13. An appeal process;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan.	
14. Process for card sharing cases;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A20.	
15. Conducting a minimum of three (3) on-site visits per quarter related to investigations of fraud, waste and abuse and reporting related information to the Department in a manner determined by the Department;	New Requirement	Full	This requirement is addressed by the sample site visit reports that were provided.	
16. Tracking the disposition of all member and provider cases (initial and preliminary) as well as case management that allows for ad hoc reporting or case status	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A16–A17.	
17. A prepayment review process in accordance with this contract; and	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A17–A18.	
18. Two (2) full-time investigators with a minimum of three (3) years Medicaid fraud, waste and abuse investigatory experience located in Kentucky dedicated 100% to the Kentucky Medicaid Program, and notification to the Department's Program Integrity Director if there is any absence or vacancy that is more than thirty (30) days with a contingency plan to remain compliant with the other contract requirements in the interim.	New Requirement	Full	The MCO is adequately staffed for their SIU. Staffing names, titles and percentage of involvement are discussed in full in the SIU Antifraud Plan on pages A15–A16. There has been no significant turnover in the Program Integrity Department.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
H. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;	Deemed for 2017	Full	This requirement is discussed in the SIU Antifraud Plan's Case Management Section.	
I. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan. The MCO's program integrity team participates by sending information to sampled members to verify that the information on the claim is correct. Members may call (which goes to a call center in Indianapolis), send an email or mail a letter in response. The information is sent to the Program Integrity Department, where the SIU receives a report of the results and takes referrals to conduct investigations as needed.	
J. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments identified and collected;	Deemed for 2017	Full	Includes review of MCO Report #75 SUR Algorithms. Overpayments are identified via claims and retro-pricing information from the state. MCO Report #75 SUR Algorithms Report lists identified overpayments, disputed amounts, revised overpayments, collected overpayments and total overpayments collected.	
9.2 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the Contractor's enrollment or projected enrollment.				
N. A Program Integrity Coordinator, who shall be located in Kentucky and whose job duties are	Full - The MCO indicated, "Kelly Hensley, a resident of KY, performs the Program	Full	This requirement is addressed in the Managed Care Plan. The MCO employs a	

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**
dedicated exclusively to the coordination, management, and oversight of the Contractor's Program Integrity unit to reduce fraud, waste and abuse of Medicaid services within Kentucky.	Integrity Coordinator role." In addition, the Anthem Kentucky Managed Care Plan, Inc. organization chart dated 12-5-16 indicates that Kelly Hensley is the staff person responsible for Program Integrity. On-site, via telephone, Kelly confirmed that she does live and work in KY, and that the Program Integrity unit indicated in the chart is specifically to reduce fraud and abuse of Medicaid services.		program integrity coordinator who meets the responsibilities set forth in this requirement.	
37.2 Prepayment Review				
The Contractor shall have policies and procedures for a prepayment review process in accordance with the requirements of this contract, and should perform a review when there is a sustained or high level of payment error or data analysis identifies a problem area. The Contractor shall have discretion on when to utilize prepayment review, but should consider such review due to a high volume of services, high cost, dramatic change in frequency of use, high risk problem-prone area, complaints, or if the Department or any other federal or state agency has identified a certain vulnerability in a service area. The Contractor shall not use prepayment review to hold claims for an indefinite period of time. The Contractor shall review the documentation submitted within a reasonable amount of time to determine whether the claim should be paid. Claims under prepayment review are not subject to prompt payment or timely filing requirements.	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A17–A19.	
Notice shall be sent to the provider in writing on or before the date a prepayment review is started. The	New Requirement	Full	The SIU Antifraud Plan describes the MCO's process for prepayments. It was discussed on	

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**
written notice shall contain the following: A. Specific reason for the review; B. Complete description of the specific documentation needed for the review and method of submission; C. Timeframe for returning the documentation, and information that the claim will be denied if documentation is not returned timely; D. Length of time the prepayment review will be conducted if the Contractor has determined one at its discretion; E. Contact information if there are questions related to the prepayment review; and F. Information on how the provider may request removal of a prepayment review.			site that notices are submitted to providers in writing on or before the date a prepayment review begins.	
The Provider shall be given forty-five (45) calendar days to submit documents in support of claims under prepayment review. The Contractor shall deny claims for which the requested documentation was not received by day forty-six (46). The Contractor shall deny a claim when the submitted documentation lacks evidence to support the service or code. The Contractor shall follow Contract Provision 28.9 for any appeals related to the prepayment process. The Contractor may extend the length of a prepayment review when it is determined necessary to prevent improper payments.	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A18.	
38.14 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions	October 2017 Review Findings	Full	Includes review of individual disclosures.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:	Full This is addressed in policy "State Notification – Disclosures of Change in Order or Controlling Interest." January 2017 Review Findings Minimal - Includes review of individual disclosures There was no relevant policy in effect during 2016 to address "The Contractor", although, effective 1/10/2017, the policy for State Notification- Disclosure of change in Ownership or Controlling Interest does address this requirement on page 14 as it applies to the Contractor. This requirement, however, is addressed for subcontractors on pages 7-8 of the Kentucky State-Specific Requirements document labeled, "Subcontractor Exhibit", which indicates that, "This Exhibit is attached to the agreement between Anthem… and ("Subcontractor") and is incorporated into the Agreement". This requirement is also addressed for subcontractors on page 4 of the Policy for Medicaid Subcontractors Disclosure of Ownership. **Recommendation for Anthem** Adopt the revised policy and include as supporting documentation in subsequent reviews. **MCO Response:** Anthem agrees with the finding and has adopted the revised Policy		This requirement is addressed in the State Notification - Disclosure of Change in Ownership or Controlling Interest Policy.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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;	October 2017 Review Findings Full This is addressed in policy "State Notification – Disclosures of Change in Order or Controlling Interest" on page 13. January 2017 Review Findings Minimal - Includes review of individual disclosures There was no relevant policy in effect during 2016 to address "The Contractor", although, effective 1/10/2017, the policy for State Notification- Disclosure of change in Ownership or Controlling Interest does address this requirement on page 14 as it applies to the Contractor. This requirement, however, is addressed for subcontractors on page 8 of the Kentucky State-Specific Requirements (and labeled as "Subcontractor Exhibit) and on pages 4-5 within the policy for Medicaid Subcontractors Disclosure of Ownership. **Recommendation for Anthem** Adopt the revised policy and include as supporting documentation in subsequent reviews. **MCO Response:** Anthem agrees with the finding and has adopted the revised Policy.	Full	Includes review of individual disclosures. This requirement is addressed in the State Notification – Disclosures of Change in Order or Controlling Interest Policy on page 15.	
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to	October 2017 Review Findings Full This is addressed in policy "State Notification – Disclosures of Change in Order	Full	Includes review of individual disclosures. This requirement is addressed in the State	

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**
subsection (a) has an ownership or control interest;	or Controlling Interest" on page 13. January 2017 Review Findings Minimal - Includes review of individual disclosures There was no relevant policy in effect during 2016 to address "The Contractor", although, effective 1/10/2017, the policy for State Notification- Disclosure of change in Ownership or Controlling Interest does address this requirement on page 14 as it applies to the Contractor. This requirement, as it applies to subcontractors, however, is addressed on page 8 (H. ii.) of the Kentucky State-Specific Requirements document labeled, "Subcontractor Exhibit". **Recommendation for Anthem** Adopt the revised policy and include as supporting documentation in subsequent reviews. **MCO Response:** Anthem agrees with the finding and has adopted the revised Policy.		Notification – Disclosures of Change in Order or Controlling Interest Policy on page 15.	
C. The same information requested in subsections (A) and (B) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $25,000 during the immediately preceding twelve-month period;	Full - Includes review of individual disclosures This requirement is addressed on page 8 (H. iii.) of the Kentucky State-Specific Requirements document labeled, "Subcontractor Exhibit".	Full	Includes review of individual disclosures. This requirement is addressed in the State Notification – Disclosures of Change in Order or Controlling Interest Policy on page 16.	
D. A description of any significant business transactions between the Contractor and any wholly-	Full - Includes review of individual disclosures	Full	Includes review of individual disclosures.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;	This requirement is addressed on page 8 (H. iv.) of the Kentucky State-Specific Requirements document labeled, "Subcontractor Exhibit".		This requirement is addressed in the State Notification – Disclosures of Change in Order or Controlling Interest Policy on page 16.	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;	Full - Includes review of individual disclosures This requirement is addressed on page 8 (H. v.) of the Kentucky State-Specific Requirements document labeled, "Subcontractor Exhibit".	Full	Includes review of individual disclosures. This requirement is addressed in the State Notification – Disclosures of Change in Order or Controlling Interest Policy on page 16.	
State Contract, Appendix N				
ORGANIZATION: The Contractor shall establish a Program Integrity Unit (PIU) to identify Fraud, Waste and Abuse and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities are conducted by staff with separate authority to direct PIU activities and functions specified in this Appendix on a continuous and on-going basis;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan and the 2018 Anthem Program Integrity Plan.	
B. Written policies, procedures, and standards of conduct demonstrate the organization's commitment to comply with all applicable contract requirements and standards and federal and state laws, regulations and standards;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan and the 2018 Anthem Program Integrity Plan.	
C. The unit establishes, controls, evaluates and	Deemed for 2017	Full	This requirement is addressed in the SIU	

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**
revises Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure compliance with all applicable contract requirements and standards and Federal and State laws, regulations and requirements;			Antifraud Plan.	
D. The staff consists of a compliance officer in addition to auditing and clinical staff;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan and the Medicaid Compliance Officer Policy.	
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:	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page 22.	
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing partnership boundaries;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
(2) High dollar amount of potential overpayment; or	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
F. Ongoing education is provided to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives; and	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
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.	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan in the SIU Associate Training Section, as well as on page 29.	
H. There are a minimum of two (2) full-time	New Requirement	Full	The MCO employs two full-time investigators.	

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**
investigators: **(1) With a minimum of three (3) years of Medicaid fraud, waste and abuse investigatory experience** **(2) Located in Kentucky; and** **(3) Dedicated 100% to the Kentucky Medicaid Program**			Investigator qualifications, experience and role within the SIU were discussed on site. The MCO is in compliance with this requirement.	
FUNCTION: Contractor and/or Contractor's PIU shall:				
A. Prevent Fraud, Waste and Abuse by identifying vulnerabilities in the Contractor's program including identification of Member and Provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
B. Proactively detect incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithms, investigations and record reviews;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
C. Determine the factual basis of allegations concerning Fraud or Abuse made by Members, Providers and other sources;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan.	
D. Initiate appropriate administrative actions to collect overpayments;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page 26.	
E. Refer potential Fraud, Waste and Abuse cases to the Department after an initial investigation for possible referral for civil and criminal prosecution and administrative sanctions, or for the	Deemed for 2017	Substantial	Fraud, waste and abuse (FWA) cases are reported to the state and referred for possible civil and criminal prosecutions, as stated in the SIU Antifraud Plan on page 17.	**Anthem Response:** Anthem agrees with the finding and is in the process of updating its policies to incorporate the required language.

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department's permission to collect overpayments in excess of $500 as an administrative recoupment or for investigation or case closure;			Language in a procedure or policy addressing permission to collect overpayments in excess of $500 as an administrative recoupment is missing from the MCO's submitted documentation. **Recommendation for MCO** The MCO should include the new contract language in their overpayment policy.	
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;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Outreach Section on page 24. The MCO also discussed on site how they are working with the state, offering knowledge on best practices, and hold monthly collaborative meetings with other MCOs in the state to share new cases and new trends.	
G. Make and receive recommendations to enhance the ability of the Parties to prevent, detect and deter Fraud, Waste or Abuse;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Outreach Section on page 24.	
H. Provide for prompt response to detected offenses and for development of corrective action initiatives relating to the Contractor's contract;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on pages 26–31.	
I. Provide for internal monitoring and auditing of Contractor and it subcontractors; and supply the Department with reports on a quarterly basis or as-requested basis on its activity and ad hocs as necessary;	Deemed for 2017	Full	This requirement is addressed in the Corrective Action – Regulatory Audits Policy. It was discussed on site that the MCO has been working with the state on enhancing and capturing information on reports that are of added benefit to both the state and the MCO in carrying out program integrity activities. Reports #71, #73, #76 and #77 were provided, which show compliance with case	

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**
			tracking requirements and state-required reporting.	
J. Be subject to on-site reviews and fully comply with requests from the Department to supply documentation and records;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page A30.	
K. Collect outstanding debt owed to the Department from members or providers; and provide monthly reports of activity and collections to the Department;	Deemed for 2017	Full	Includes review of MCO Report #71 Provider Outstanding Account Receivables. This requirement is addressed in the SIU Antifraud Plan's Reporting Section on page A26. Report #71 was provided to show compliance with this requirement. Other reporting activities were discussed on site.	
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;	Deemed for 2017	Non-Compliance	This requirement was not addressed in a policy or procedure.	**Anthem Response**: Anthem agrees with the finding. The SIU has added the language to the revised AntiFraud Plan, page A5, item #15, and page A19, item #1.8.
M. The Contractor shall, as requested by the Department, recoup on any outstanding provider overpayments not identified by the Contractor if the provider has exhausted all appeals and the provider fails to pay the Department within sixty (60) days, and remit the amount or balance within sixty (60) days of notification by the Department;	New Requirement	Full	This requirement is addressed in the CPI Policy on page 2. A sample overpayment letter was provided as evidence of the implementation of this requirement.	
N. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals, for the purpose of identifying potentially fraudulent acts;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page A3.	
O. Conduct regular post-payment audits of Provider	Deemed for 2017	Full	This requirement is addressed in the SIU	

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**
billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Department;			Antifraud Plan on pages A3–A4.	
P. Conduct onsite and desk audits of Providers and report the results including identified overpayments and recommendations to the Department;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page A26.	
Q. Locally maintain cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan. The MCO discussed their case management and reporting system on site. Cases are maintained locally, and reports can be generated on these cases.	
R. Designate a contact person to work with staff investigators and attorneys from the Department OIG and any other agent or contractor of the Department;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page A21.	
S. Ensure the integrity of PIU referrals to the Department and shall not subject referrals to the approval of the Contractor's management or officials;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's External Review Request Section on page A30.	
T. Comply with the expectations of 42 CFR 455.20 by employing a method of verifying with a Member whether the services billed by Provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;	Deemed for 2017	Full	Includes review of MCO Report # 73 Explanation of Member Benefits (EOMB). The MCO provided Report #73 of all member services rendered. The MCO's program integrity team participates by sending information to sampled members to verify that the information on the claim is correct. Members may call, send an email or mail a letter in response. The information is sent to the Program Integrity Department, where the SIU receives a report of the results and takes	

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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**
			referrals to conduct investigations as needed.	
U. Run algorithms on billed claims data over a time span sufficient to identify potential fraudulent billing patterns and develop a process and report quarterly or as otherwise requested to the Department all algorithms, issues identified, actions taken to address those issues and the overpayments collected;	Deemed for 2017	Full	Includes review of MCO Report #75 SUR Algorithms. This requirement is addressed in Report #75.	
V. Collect administratively from Members for overpayments that were declined prosecution for Medicaid Program Violations (MPV);	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page A3.	
W. Comply with the program integrity requirements set forth in the Patient Protection and Affordable Care Act, specifically 42 CFR 438.608, and all applicable requirements and standards under this contract and any federal and state laws and regulations, and provide policies and procedures to the Department for review and approval;	Deemed for 2017	Full	This requirement is addressed in the 2018 Anthem Ethics and Compliance Plan on page 12.	
X. Report to the Department any Provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, within 5 days of the enrollment denial;	Deemed for 2017	Full	This requirement is addressed in the Credentialing Tool Report on pages 16, 67 and 267.	
Y. Recover overpayments from providers;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on pages A3–A4.	
Z. Identify Providers for pre-payment review as a result of the Provider's activities in accordance with the contract;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on pages A18.	
AA. Conduct a minimum of three (3) on-site visits per quarter related to investigations of suspected fraud and abuse. The site visit shall be approved within a	New Requirement	Non-Compliance	Site visits are broadly addressed in the SIU Antifraud Plan on page 21. The specific language of the requirement, including	**Anthem Response:** Anthem agrees with the finding. The SIU has added the language to the revised AntiFraud

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**
minimum of ten (10) calendar days by the Department;			language regarding three onsite visit and approval within 10 calendar days, is missing from the policy.	Plan, page A5, item #16.
BB. Notify the Department if there is an absence or vacancy in an investigator position that is longer than thirty (30) days, and include a contingency plan to remain compliant with the contract requirements in the interim; and	New Requirement	Full	As discussed on site, there is no significant turnover and SIU is adequately staffed. SIU is compliant with the state's requirements in regards to staffing for investigator positions.	
Z. Correct any weaknesses, deficiencies, or noncompliance items identified as a result of a review or audit conducted by the Department, CMS, or by any other State or Federal Agency or agents thereof that has oversight of the Medicaid program. Corrective action shall be completed the earlier of thirty (30) calendar days or the timeframes established by Federal and state laws and regulations.	Deemed for 2017	Full	This requirement is addressed in the Corrective Action Policy.	
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law with copy to the Department and OIG. Potential Member safety issues related to investigations shall be reported in accordance with state law with a copy to the Department's Program Integrity Division Director and Program Quality & Outcomes Division Director.	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan. Patient safety is addressed on page 29 and complaint system description is addressed on page A29.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
COMPLAINT SYSTEM: The Contractor's PIU shall have an operational system to receive, investigate and track the status of Fraud, Waste and Abuse complaints from Members, Providers and all other sources which may be made against the Contractor, Providers or Members. The system shall contain the following:				
A. Upon receipt of a complaint or other indication of potential Fraud or Abuse, the Contractor's PIU shall conduct an initial investigation to determine the validity of the complaint;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A3.	
B. The PIU should review background information and MIS data; however, the initial investigation should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A3.	
C. If the initial investigation results in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to the Department; however, the PIU shall take whatever remedial actions may be necessary, up to and including administrative recovery of identified overpayments;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A3.	
D. If the initial investigation results in a reasonable belief that Fraud or Abuse has occurred, the PIU shall refer the case and all supporting documentation to the, the Department;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A3.	
E. The Department will review the referral and attached documentation, make a determination and notify the PIU as to whether the OIG will investigate the case or return it to the PIU for appropriate administrative action;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page 3.	

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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**
F. If in the process of conducting a initial investigation, the PIU suspects a violation of either criminal Medicaid Fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the Department of their findings and proceed only in accordance with instructions received from the Department;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A3.	
G. If the Department determines that it will keep a case referred by the PIU to the OIG, the OIG will conduct a preliminary investigation review the PIU's report and evidence, gather additional evidence if needed, and forward information if warranted, to the Attorney General's Medicaid Fraud Control Unit, for appropriate action;	Deemed for 2017			
H. If the OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the preliminary investigation, provide a copy of the investigative report to the Department, the PIU, or if warranted, to MFCU, for appropriate actions;				
I. If the OIG investigation results in a referral to the MFCU and/or the U.S. Attorney, the OIG will notify the Department and the PIU of the referral. The Department and the PIU shall only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
J. Upon approval of the Department, Contractor shall suspend and escrow Provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page 45.	

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**
K. Upon completion of the PIU's initial investigation, the PIU shall provide the Department a copy of their investigative report, which shall contain the following elements:	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4.	
(1) Name and address of subject,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(2) Medicaid identification number,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(3) Source of complaint,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary	

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**
			Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(4) State the complaint/allegation,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(5) Date assigned to the investigator,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(6) Name of investigator,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(7) Date of completion,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Three (3) of 9 files were compliant for this requirement. Five (5) of the 9 files were provider investigations that are still ongoing; as a result, the completion dates did not apply.	
(8) Detail as to what timeframe was reviewed;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were	

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**
			submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(9) How many member records were reviewed for that timeframe and the total of number of claims;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(10) The issues identified;	New Requirement	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(11) Methodology used during investigation,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Program Integrity File Review Results Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(12) Facts discovered by the investigation as well as the full case report and supporting documentation,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(13) Attach all exhibits or supporting documentation,	Deemed for 2017	Full	Includes program integrity file review results. This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(14) Include recommendations as considered	Deemed for 2017	Full	Includes program integrity file review results.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
necessary, for administrative action or policy revision,			This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement on page A4. **Program Integrity File Review Results** Eight (8) of 9 files were compliant for this requirement. Nine (9) total files were submitted for review; 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(15) Identify overpayment, if any, and recommendation concerning collection,	Deemed for 2017	Full	Includes program integrity file review results. **Program Integrity File Review Results** Four (4) of 9 files were compliant for this requirement. This requirement did not apply to the other 4 files, since they did not involve overpayments. 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(16) Reason for closure of the report, if applicable;	New Requirement	Full	Includes program integrity file review results. **Program Integrity File Review Results** Three (3) of 9 files were compliant for this requirement. Five (5) of 9 files were provider investigations that are still ongoing or had a request for closure; as a result, completion dates did not apply. 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(17) Request to send as a referral for a preliminary investigation for a credible allegation of fraud, if	New Requirement	Full	Includes program integrity file review results.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
applicable; and			**Program Integrity File Review Results** One (1) of 9 files was compliant for this requirement; remaining 7 files were not applicable. 1 file was not applicable, as it was incorrectly labeled as a file within the universe.	
(18) Any other elements identified by CMS for fraud referral;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan under Process Summary Restatement.	
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;	Deemed for 2017	Full	Includes review of MCO Report #76 Provider Fraud Waste Abuse Report and #77 Member Fraud Waste Abuse Report. This requirement is addressed by reports #76 and #77.	
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	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Case Tracking System Section on page A16.	
N. The Contractor's PIU shall assure a Grievance and Appeal process for Members and Providers in accordance with 907 KAR 1:671.	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Addendum.	
CASE TRACKING AND CASE MANAGEMENT (a) The Contactor shall have a case tracking and case management system to track member and provider cases; (b) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be	New Requirement	Substantial	The SIU Antifraud Plan addresses case tracking and case management systems on pages A16 to A17, and reporting responsibilities on page 27. Also, reports of all SIU investigations and data elements submitted are discussed on pages A3 to A4. As discussed and viewed on site, the MCO does have the capability to query for ad hoc reporting or case status through their case	**Anthem Response:** Anthem agrees with the finding and is in the process of updating its policies to incorporate the required language/data elements.

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
able to report the following for provider cases: (1) PIU Case number, (2) Provider name, (3) Provider number, (4) NPI (if applicable), (6) Source of Complaint, (7) OIG Referral Number (if applicable), (8) MAT Case Y/N (if applicable to report), (9) Date complaint received by Contractor, (10) Date opened, (11) Name of PIU investigator assigned, (12) Summary of Complaint, (13) Justification that a referral for a preliminary investigation was not warranted based upon the evidence in the case file, (14) PIU action(s) taken and date(s), (15) Amount of overpayment if any (please note potential overpayments of $500 or more should be referred for preliminary investigation), (16) Administrative actions (if any) or referral with description, and (17) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file. (c) The Contractor shall have the ability to query for ad hoc reporting or case status through the case tracking system for any period of time and shall be able to report the following for member cases: (1) PIU Case number,			tracking system for any period of time. During the onsite program integrity file review, SIU staff discussed tracking of cases and reporting of cases for both member- and provider-related cases. All data elements were checked for the program integrity file review cases, and although the Program Integrity Unit (PIU) investigator names are missing from reports #76 and #77 (April 2018 reports), the MCO has this information in their systems and is able to report on it, if requested. The field "PIU Actions Taken" addresses both items (14) and (16) of the requirement, as both administrative actions and PIU actions are noted in this field. For member cases, the MCO's Report #77 (April 2018) captures all data elements except for elements (4), (5), (7), (10) and (12). However, the MCO meets the minimum requested specifications for Report #77 based on the sample file layout listed in the contract. The field "Actions Taken" addresses element (15). Per DMS, Appendix N would supersede Appendix K as Appendix N has been updated to reflect changes brought forth from the CMS Focus Review. The MCOs were notified of the changes by letter dated August 30, 2017 **Recommendation for MCO**	

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**
(2) Member name, (3) Member number, (4) Date of Birth (if known), (5) Social Security Number (if known), (6) Source of Complaint, (7) OIG Referral Number (if applicable), (8) Date complaint received by Contractor, (9) Date opened, (10) Name of PIU investigator assigned, (11) Summary of Complaint, (12) Justification that a preliminary investigation was not warranted based upon the evidence in the case file, (13) PIU action(s) taken and date(s) within the ten (10) day review period, (14) Amount of overpayment if any, (15) Administrative actions (if any) or referral with description, (16) Closure Date* (if applicable) of initial investigation with approval from supervisor. Supervisor approval should demonstrate/attest verification of each component in the case file.			The MCO should include in a separate policy or procedure for case tracking and reporting that address the specific language of this requirement. Although the MCO is following the sample layout indicated in the contract for reports #76 and #77, the MCO should include missing data elements in requested reports as required by this contractual language.	
REPORTING: A. The Contractor's PIU shall report on a monthly basis provider internal referrals (tips) and the disposition of the prior month's internal referrals, and on a quarterly basis in a narrative report format, as required by the Department, all activities and processes for each investigative case (for that quarter to the Department. The Contractor shall have the ability to report all aspects of a member or provider file from opening to closure) to the Department upon request, including overpayments identified, overpayment adjusted and recoupments	Deemed for 2017	Substantial	Includes review of MCO Report #76 and Report #77. General reporting and regulatory reporting requirements are discussed in the SIU Antifraud Plan on page A25–A26. For reports #76 and #77 with member and provider cases reported, all aspects of the investigation were captured from the opening to the closure. Report #75 SUR Algorithm captured information on overpayments and recoupment information.	**Anthem Response:** Anthem agrees with the finding and is in the process of updating its policies to incorporate the required language/data elements.

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**
of overpayments;			**Recommendation for MCO** The MCO should incorporate all data elements requested in the reports.	
B. If any employee or subcontractor employee of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A26.	
C. The Contractor's PIU shall immediately report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and the Department in adherence to state requirements.	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A26.	
D. The Contractor shall adhere to all ad hoc reporting requests whether one time or recurring in accordance with Section 38.1 of this contract;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan.	
E. The Contractor shall report all overpayments identified as prescribed by the Department;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan and by report #75.	
F. The Contractor shall report the collection of provider overpayments and the prepayment cost avoidance in relation to the quarterly total of Monthly Benefit Payments;	New Requirement	Full	This requirement is addressed in the SIU Antifraud Plan on page A10.	
G. The Contractor shall report the escrow of provider payments in adherence to state requirements;	New Requirement	Full	Escrow reports were provided to show compliance with this item.	
H. The Contractor shall report site visits conducted in adherence to state requirements; and	New Requirement	Full	A sample site visit report was provided to show compliance with this requirement. The SIU Antifraud Plan also mentions this requirement.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
I. The Contractor is required to report the following data elements to the Department and the OIG on a quarterly basis, in an excel format:	Deemed for 2017	Full	Includes review of MCO Report #76 and Report #77. Reports #76 and #77 were provided for 2017 and 2018.	
(1) PIU Case number;	Deemed for 2017	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(2) Provider /Member name;	Deemed for 2017	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(3) Provider Medicaid ID /Member Medicaid number;	Deemed for 2017	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(4) Date complaint received by Contractor;	Deemed for 2017	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(5) Provider NPI (if nonmember case);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(6) Source of complaint		Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(7) OIG Case Number	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(8) Date complaint or referral received	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(9) Date opened		Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(10) MAT related (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in Report #76, which meets requirements listed for case management and tracking for provider cases.	
(11) Summary of complaint with timeframe reviewed;		Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
(12) Initial investigation (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(13) Actions taken;	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
(14) Referred to DMS (with appropriate code);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in Report 76, which is in compliance with the MCO contract sample layout for report #76 and #77.	
(15) Date referred to DMS (if applicable)	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in Report 76, which is in compliance with the MCO contract sample layout for report #76 and #77.	
(16) Provider on prepayment (Y or N);	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in Report 76, which is in compliance with the MCO contract sample layout for report #76 and #77.	
(17) Overpayment identified, and	New Requirement	Full	Includes review of MCO Report #76 and Report #77.	

Final Findings

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This requirement is listed in the sample reports from April 2018.	
(18) Date case closed (if applicable).	New Requirement	Full	Includes review of MCO Report #76 and Report #77. This requirement is listed in the sample reports from April 2018.	
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;	Deemed for 2017	Full	The MCO provided pre-onsite documentation for various audit sections such as Health Information Systems (HIS), Access, Grievances and Appeals which shows supporting documentation, investigative reports, sample letters and subcontractor policies, which meet compliance for this requirement.	
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department the OIG and any other agent or contractor of the Department;	Deemed for 2017	Full	The MCO provided pre-onsite documentation for various audit sections such as Health Information Systems (HIS), Access, Grievances and Appeals which shows supporting documentation, investigative reports, sample letters and subcontractor policies, which meet compliance for this requirement.	
C. Backup, store or be able to recreate reported data upon demand for the Department the OIG and any other agent or contractor of the Department;	Deemed for 2017	Full	The MCO has reporting systems in place to create reported data and any ad hoc requests as required by DMS as discussed in the SIU Antifraud Plan.	
D. Permit reviews, investigations or audits of all	Deemed for 2017	Full	This requirement is addressed in the SIU	

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**
books, records or other data, at the discretion of the Department the OIG any other agent or contractor of the Department, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;			Antifraud Plan's Access to Information Section.	
E. Produce records in electronic format for review and manipulation by the Department the OIG and any other agent or contractor of the Department;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Access to Information Section on page 28.	
F. Allow designated Department staff, the OIG, and any other agent or contractor of the Department read access to ALL data in the Contractor's MIS systems;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Case Management Section on page A17.	
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;	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan on page 28–29.	
H. Fully cooperate with the Department, the OIG any other agent or contractor of the Department, the United States Attorney's Office and other law enforcement agencies in the investigation or Fraud or Abuse cases; and	Deemed for 2017	Full	This requirement is addressed in the SIU Antifraud Plan's Case Management Section on page A17.	
I. Provide identity and cover documents and information for law enforcement investigators under cover.	Deemed for 2017	Full	The MCO stated in the pre-onsite discussion that they are currently in discussion with DMS and the Office of the Inspector General (OIG) in regards to the provision for cover credentials. Undercover activities are listed and discussed in the SIU Antifraud Plan on page 24.	

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October 2018
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MCO: Anthem Blue Cross Blue Shield

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	142	3	0	2
Total Points	426	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		**2.94**		

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 (NA)	Statement does not require a review decision; for reviewer information purposes

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

Final Findings

Program Integrity

Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

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

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.1 EPSDT Early and Periodic Screening, Diagnosis and Treatment				
The Contractor shall provide all Members under the age of twenty-one (21) years except those eligible pursuant to 907 KAR 4:030, EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix M. The Contractor shall comply with 907 KAR 1:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.	Deemed for 2017	Full	This requirement is addressed in MCO Report #93 EPSDT CMS-416 and MCO Report #24.	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:	Deemed for 2017	Full	This requirement is addressed in the EPSDT Services – Core Policy on pages 5–7 and in the Provider Administration of EPSDT Screenings and Special Services Policy on pages 2–5.	
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.	Deemed for 2017	Full	This requirement is addressed in EPSDT Services – Core Policy20.docx 2017 FD and in KY Medicaid EPSDT Provider Toolkit December 2014.	
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.	Deemed for 2017	Full	This requirement is addressed in the Corporate Monitoring and Outreach Policy, EPSDT Services Core Policy, EPSDT Services – Core Policy20.docx 2017 FD, Anthem Member Handbook 2018, and in the Immunization Outreach 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**
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.	Full - Includes file review results for EPSDT Appeal files This requirement is addressed on page 5 of the EPSDT Program Overview for KY Medicaid and in the document EPSDT_2_KKY UM Medicaid Appeal Right, and on pages 18 (EPSDT benefits) and 47 (appeals) of the Member Handbook. In addition, the letter labeled "EPSDT_2_Redacted letter with SFH liability language.pdf" does address the prior year recommendation regarding how to request continuation of benefits and member potential liability for SFH upheld decisions. <u>File Review Findings EPSDT Appeals</u> 5 of 5 files reviewed met the requirements for timeliness of resolution notice, timely acknowledgement of receipt of appeal, reviewer not involved in previous level of review, member provided with opportunity to examine case file, member provided opportunity to present evidence, parties to the appeal, resolution notice included date and results.	Full	Includes file review results for EPSDT utilization management (UM) files and EPSDT appeal files. This requirement is addressed in the section on grievances and medical appeals in the Anthem Member Handbook 2018.	

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**
	4 of 5 files met the requirement that the reviewer is a health care professional with appropriate clinical expertise; however, this requirement did not apply to 1 of the files which entailed an authorization request that was resubmitted by the provider and approved. 4 of 5 files met the requirements for member notification of the right to request a State Fair Hearing, the right for continuation of benefits, and the potential for member cost liability; however, these requirements did not apply to 1 of the files which entailed an authorization request that was resubmitted by the provider and approved. There were no expedited appeals or extensions granted.			
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix M.	Deemed for 2017	Full	This requirement is addressed in the EPSDT Services - Core Policy, Anthem Member Handbook 2018, and in KY Medicaid EPSDT Provider Toolkit December 2014 and an updated EPSDT Toolkit revised in 2018 .	
D. Provide all needed initial, periodic and inter-periodic health	Deemed for 2017	Full	This requirement is addressed in the EPSDT	

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**
assessments in accordance with 907 KAR 1:034. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.			Services – Core Policy and the KY Medicaid Provider Manual 2017.	
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers shall provide treatment if the service is not available with the Contractor's Network.	Full - This requirement is addressed on pages 56-58 of the Provider Manual, with out of area/out of network care addressed on page 67. On site, Anthem provided the EPSDT Toolkit, which is distributed to providers in the Contractor's network.	Full	This requirement is addressed in the EPSDT Services – Core Policy on page 10; EPSDT Screening and Special Services Policy in the Provider Administration Section on page 18; and in the EPSDT Provider Toolkit 2014 and an updated EPSDT Toolkit revised in 2018.	
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix M.	Full - Evidence in support of the requirement for qualified EPSDT providers was found on page 7 of the EPSDT Program Overview for KY Medicaid and in support of the requirement for special services covered subject to prior authorization on page 58 of the Provider Manual.	Full	This requirement is addressed in the EPSDT Screenings and Special Services Policy, Provider Administration Section on pages 11–13 and in the KY Medicaid Provider Manual 2017.	
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.	Full - Evidence in support of the requirement for a system to track receipt of EPSDT services was found in the MPOS 2016 Screen Shots.pdf, with evidence of a system to track EPSDT refusals in the Refused EPSDT	Full	This requirement is addressed in the EPSDT Screenings and Special Services Policy, Provider Administration Section, and in the EPSDT Refused Outreach 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**
	Outreach Report. On site, Anthem explained processes for tracking/monitoring acceptance and refusal of EPSDT services (e.g., chart reviews, UM preauthrorization) and demonstrated the Member/Provider Outreach System.			
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.	Deemed for 2017	Full	This requirement is addressed in the KY Medicaid Provider Manual 2017 and 360 SNIP.pngIPRO, a screenshot of the member care summary.	
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.	Deemed for 2017	Full	This requirement is addressed in the EPSDT Refused Outreach Report and the Provider Administration of EPSDT Screenings and Special Services Policy.	
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.	Deemed for 2017	Full	This requirement is addressed in the Coordination of Care Between Physical and Behavioral Health Care Providers 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**
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 Pediatric Interface-School Based Services-KY Policy.	
K. Participate in any state or federally required chart audit or quality assurance study.	Deemed for 2017	Full	This requirement is addressed in Anthem_attachmentB2017 vpm2017, the performance measure validation reporting tool.	
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.	Full - Evidence in support of this requirement was found on page 8 of the EPSDT Program Overview, which addresses the conduct of training through the provider portal, as well as the distribution of an EPSDT Provider Toolkit to all EPSDT providers, which was further supported by On-site Provider Summary Sheets that specifically addressed sharing of EPSDT toolkits with providers. On site, Anthem provided the EPSDT Provider Toolkit.	Full	This requirement is addressed in the Provider Administration of EPSDT Screenings and Special Services Policy, KY Medicaid Provider Manual, and in the KY Medicaid EPSDT Provider Toolkit.	
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.	Deemed for 2017	Full	This requirement is addressed in AN_Reports_180315_Report93.	

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October 2018
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MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.	Deemed for 2017	Full	This requirement is addressed in EPSDT Quality Coordinator and in Anthem BCBS KY Medicaid QM Program Evaluation 2017.	
9.2 Administration/Staffing				
I. The Contractor shall provide the functions and positions that shall be staffed by a sufficient number of qualified individuals to adequately provide for the Contractor's enrollment or projected enrollment. An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Coordinator, who shall coordinate and arrange for the provision of EPSDT services and EPSDT special services for Members.	New Requirement	Full	This requirement is addressed in EPSDT Quality Coordinator and in Anthem BCBS KY Medicaid QM Program Evaluation 2017.	
23.1 Required Functions				
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Deemed for 2017	Full	This requirement is addressed in EPSDT Program Overview and in KY Medicaid EPSDT Clinic Days Training.	
38.9 EPSDT Reports				
The Contractor shall submit Encounter Files to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter File shall be completed according to the requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.	Deemed for 2017	Full	Includes review of MCO Report #93 EPSDT CMS-416. This requirement is addressed in AN_Reports_180315_Report93.	

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October 2018
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MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	21	0	0	0
Total Points	63	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

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

Documents

Policies/procedures for:

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

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

Reports

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

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4.3 Delegations of Authority				
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in the Subcontracts section, Contractor agrees to the following provisions.				
A. There shall be a written agreement that specifies				
1. Delegated activities and reporting responsibilities of the Subcontractor	Deemed for 2017	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Fifteen (15) of 17 contracts reviewed met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement contains the required language.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
2. Subcontractor agrees to comply with all applicable Medicaid laws and regulations including applicable sub-regulatory guidance and contract provisions;	New Requirement	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Twelve (12) of 17 contracts reviewed met this requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for MCO The MCO should ensure that every subcontractor agreement contains the required language.	
3. The right of the state, CMS, HHS Inspector General, the Comptroller General or their designee to audit, evaluate and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, determination of amounts payable under the MCO's contract with the State, or for reasonable possibility of fraud or similar risk;	New Requirement	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Twelve (12) of 17 contracts reviewed met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement contains the required language.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
4. Subcontractor will make its premises, physical facilities, equipment, books records, contracts, computer or other electronic systems relating to its Medicaid enrollees available;	New Requirement	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Twelve (12) of 17 contracts reviewed met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement contains the required language.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.

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**
5. The right to audit through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later; and	New Requirement	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Twelve (12) of 17 contracts reviewed met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement contains the required language.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
6. provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate	Deemed for 2017	Full	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Seventeen (17) of 17 contracts reviewed met this requirement.	
B. Before any delegation, the Contractor shall evaluate the prospective Subcontractor's ability to perform the activities to be delegated.	Deemed for 2017	Full	Includes review results for each subcontractor. This requirement is addressed in the Delegate Vendor Oversight and Management Program. One (1) of 17 delegates had a contract with an effective date within the review period. The other 16 are deemed not-applicable for this requirement. The one (1)	

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**
			contract reviewed met this requirement.	
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.	Deemed for 2017	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Delegate Vendor Oversight and Management Program. One (1) of 17 delegates had a contract with an effective date within the review period. This delegate would not necessarily have a formal review during the period. The other 16 were reviewed for this requirement. Eleven (11) of 16 contracts reviewed met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor is monitored on an ongoing basis and is formally reviewed annually.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all monitoring and oversight of its subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.	Deemed for 2017	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Delegate Vendor Oversight and Management Program. One (1) of 17 delegates had a contract with an effective date within the review period. This delegate would not necessarily have a formal review during the period.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all monitoring and oversight of its subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.

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 other 16 were reviewed for this requirement. Eleven (11) of 16 contracts reviewed met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor is monitored on an ongoing basis and is reviewed annually for deficiencies or areas for improvement.	
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.	Deemed for 2017	Full	Includes review results for each subcontractor. This requirement is addressed in the Delegate Vendor Oversight and Management Program. Four (4) of 17 delegates had a contract that includes selection of providers. The other 13 were designated not applicable for this requirement. Four (4) of four (4) contracts reviewed met this requirement.	
F. The Contractor shall assure that the Subcontractor is in compliance with all Medicaid laws and regulations including applicable subregulatory guidance and contract provisions.	Deemed for 2017	Full	This requirement is addressed in the Delegate Vendor Oversight and Management Program.	
6.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its	Deemed for 2017	Substantial	Includes review results for each subcontractor.	**Anthem Response:** Anthem agrees with this finding.

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**
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.			This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Twelve (12) of 17 files met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement contains the required language.	Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
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.	Deemed for 2017	Substantial	Includes review results for each subcontractor. This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement contains the required language.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
6.2 Requirements				
The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member, except the Contractor shall not enter into any Subcontract with	Deemed for 2017	Full	This requirement is addressed in the Medicaid Compliance Subcontractor Management Due Diligence Policy.	

Final Findings

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

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for MCO The MCO should ensure that every subcontractor agreement contains the required language and is appended with a clear Statement of Work as well as the complete Kentucky Medicaid flow downs.	contract. Compliance, Regulatory Services and Vendor Management are meeting to ensure all contract revision language is included and subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
A. Identify the population covered by the Subcontract;	Deemed for 2017	Substantial	Includes review results for each subcontractor. Sixteen (16) of 17 subcontracts met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;	Deemed for 2017	Full	Includes review results for each subcontractor. Seventeen (17) of 17 subcontracts met this requirement.	
C. Specify procedures and criteria for extension, renegotiation, and termination;	Deemed for 2017	Full	Includes review results for each subcontractor. Seventeen (17) of 17 subcontracts met this requirement.	
D. Specify that Subcontractors use only Medicaid enrolled providers in accordance with this Contract;	Deemed for 2017	Full	Includes review results for each subcontractor.	

Final Findings

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			This requirement is applicable for four (4) of 17 (seventeen) contracts. Four (4) of four (4) met this requirement.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;	Deemed for 2017	Full	Includes review results for each subcontractor. Seventeen (17) of 17 met this requirement.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;	Deemed for 2017	Full	Includes review results for each subcontractor. Seventeen (17) of 17 met this requirement.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;	Deemed for 2017	Full	Includes review results for each subcontractor. This requirement is applicable for two (2) of 17 contracts. Two (2) of two (2) met this requirement.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;	Deemed for 2017	Substantial	Includes review results for each subcontractor Twelve (12) of 17 contracts met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.

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**
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;	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the specifications required by this Contract;	Deemed for 2017	Full	Includes review results for each subcontractor. This requirement is applicable for two (2) of 17 contracts. Two (2) of two (2) contracts met this requirement.	
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,				
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 contracts met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.

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**
(2) all QAPI requirements,	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
(3) all record keeping and reporting requirements,	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
(4) all obligations to maintain the confidentiality of information,	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
(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	Deemed for 2017	Substantial	Includes review results for each subcontractor.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and

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**
Commonwealth agents to inspect, investigate, monitor and audit operations,			Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
(6) all indemnification and insurance requirements, and	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
(7) all obligations upon termination;	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
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	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to

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**
schedule consistent with industry standards, but no less than annually;			**Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	include execution date requirement to mitigate future deficiencies is in development.
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.	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
O. The remedies up to, and including, revocation of the Subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in

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**
			contractual requirement.	development.
P. Contain provisions that suspected fraud and abuse be reported to the contractor.	Deemed for 2017	Substantial	Includes review results for each subcontractor. Twelve (12) of 17 met this requirement. **Recommendation for MCO** The MCO should ensure that every subcontractor agreement meets the contractual requirement.	**Anthem Response:** Anthem agrees with this finding. Compliance, Regulatory Services and Vendor Management are meeting to ensure all subcontracts are in compliance. A procedure including a checklist to include execution date requirement to mitigate future deficiencies is in development.
The requirements would be applicable to Subcontractors characterized as Risk contracts. The requirements of this section shall not apply to Subcontracts for administrative services or other vendor contracts that do not provide Covered Services to Members.	Deemed for 2017			
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.	Deemed for 2017			

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October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

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	12	24	0	0
Total Points	36	48	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.33**		

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

Reviewer Decision:

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

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

Final Findings

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

Documents

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

Reports

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

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MCO: Anthem Blue Cross Blue Shield Medicaid

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MCO Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
16.1 Encounter Data Submission				
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Files set in formats and timelines prescribed by the Department as defined in the Contract.	Deem for 2017	Full	The MCO has addressed this requirement. The MCO provided their KY Edifics Encounter Data Validation Policy. Staff was present at the onsite to discuss claims adjudication processes, encounter submissions and rectification of erred encounters.	
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter identification number for each Encounter.	Deem for 2017	Full	The MCO has addressed this requirement. All encounters have a unique identifier for tracking.	
At a minimum, the Contractor shall be required to electronically provide Encounter Files to the Department, on a weekly schedule.	Deem for 2017	Full	The MCO has addressed this requirement. As discussed onsite, encounters are submitted on a weekly basis. The MCO is in full compliance with this requirement.	
Encounter Files must follow the format, data elements and method of transmission specified by the Department.	Deem for 2017	Full	The MCO has addressed this requirement. For encounter submissions, technical workgroup encounter meeting notes indicate the MCO has regular follow-up with the state on encounter submissions and identification of issues, if any.	
All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible. Other edits and processing requirements shall be provided to the Contractor in writing no less than thirty (30) business days prior to implementation.	Deem for 2017			
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.	Deem for 2017	Full	The MCO was not requested to send any electronic test data files during the audit time period.	

Final Findings

MCO Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The electronic test files are subject to Department review and approval before production of data.	Deem for 2017	Full	The MCO was not requested to send any electronic test data files during the audit time period.	
The Contractor shall have the capacity to track and report on all Erred Encounter Records.	Deem for 2017	Full	The MCO has processes in place to track and report on all erred encounter records; the remediation process for rejected encounters was discussed by onsite audit attendees. In addition the KY Edifics procedure document and onsite discussion about encounter error resolution, the MCO provided a screenshot of the encounter KY Issue Resolution Flow and a screenshot of their Encounter Reject Dashboard which tracks aging rejected encounters by claim type.	
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounters in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounters as directed by the Department.	Deem for 2017	Full	The MCO has addressed this requirement. Weekly encounter submissions are submitted, as per state standards, for file layouts and data elements.	
All Subcontracts with Providers or other vendors of service must have provisions requiring that an Encounter is reported/submitted in an accurate and timely fashion.	Deem for 2017	Full	Anthem's dental, vision and pharmacy vendors submit encounter data. Subcontractor agreements with the MCO's dental vendor, DentaQuest, and vision vendor, EyeQuest, were provided to show compliance with this requirement. Anthem also submitted provider agreement documents, subcontractor agreement and claims adjudication procedures from ESI, and their pharmacy vendor who handles pharmacy claims adjudication. Within the agreements, the Section 2. 6 titled,	

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MCO Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			"Encounter Data: Other Reports" lists the subcontractor responsibilities in providing encounter data in an accurate and timely manner. In addition to this, a KY Vendor Flow diagram was provided to show internal processes for data received from dental and eye vendors.	
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounters, and a secondary contact person in the event the primary contract person is not available.	Deem for 2017	Full	The MCO has addressed this requirement. Technical Encounter Workgroup meeting minutes hosted by DMS were provided and included the names of individuals involved in the MCO's encounter submissions processes.	
16.2 Technical Workgroup				
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter submission.	Deem for 2017	Full	The MCO has addressed this requirement. Monthly Technical Workgroup meeting minutes were provided with a list of the attendees, topics discussed, outstanding items for discussion and follow-up items.	
17.0 Kentucky Health Information Exchange (KHIE)				
The Contractor shall encourage all Providers in their Network to establish connectivity with the KHIE. For newly contracted providers, the Contractor shall notify the Provider within one month of the recommendation to sign a Participation Agreement with KHIE for the purpose of connecting their electronic health records system to the health information exchange to share their patient electronic records. The data set required for submission is a Summary of Care Record.	New Requirement	NA	The provider manual that was active during the audit time period does not include language addressing providers sign-up with KHIE. The MCO provided sample provider letters for newly contracted providers. The current language in the sample letter(s) provided is as such: "As a provider in Kentucky, we recommend you register with the Kentucky	**Anthem Response:** For this new requirement, Anthem will ensure that the draft versions of the provider letter and Provider Manual will include the contract language in full and will be used in place of the original document.

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MCO 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**
			Health Information Exchange (KHIE) to connect your electronic health record system to the health information exchange and/or sign up for secure messaging to share clinical information with other providers. Please visit the KHIE website at http://khie.ky.gov for more information." Additionally, the MCO provided a sample provider site visit form which includes the KHIE checkbox for addressing. As discussed onsite, providers are encouraged to sign up for KHIE during provider site visits. The provided documentation shows encouragement is shared with newly contracted providers during the time frame and not all providers in the MCOs network. **Recommendation for MCO** The MCO provided a draft version of their provider letter and provider manual that address most of the new contract language; however, these draft versions were outside the scope of the audit time frame. It is recommended that the draft version addresses the contract language in full and is used in place of the original document.	
For hospitals, the Contractor shall also recommend the submission of ADTs (Admission, Discharge, Transfer messages) to KHIE.	New Requirement	NA	The sample provider letter to individual and facility providers was submitted. However, language addressing that hospitals submit admission, discharge, transfer messages to KHIE is missing.	**Anthem Response:** Anthem accepted this recommendation and provided a redlined version of the provider manual with the following added: "Hospitals are also encouraged to submit

Final Findings

MCO 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**
			Recommendation for MCO The MCO should include this language in their provider manual, provider letter and other provider materials used to communicate with hospital facilities to show compliance with this new contract requirement.	admission, discharge and transfer (ADT) messages to KHIE." Additionally, the provider letter will be revised to include this specific sentence.
If the provider does not have an electronic health record the Contractor will encourage the Provider to sign a Participation Agreement with KHIE as well as sign up for Direct Secure Messaging services so that clinical information can be shared securely with other providers in their community of care.	New Requirement	NA	This information is missing from the provider manual for the audit time period. The sample provider letter recommends that providers connect their electronic health record (EHR) system to the health information exchange and/or sign up for secure messaging to share clinical information with other providers. This recommendation does not address the specific language for providers without EHR. It also gives providers a choice of signing up for KHIE or the service messaging services rather than require they do both. **Recommendation for MCO** The MCO should update its provider letters and provider manual to address the new contract requirement. The MCO did provide draft versions of its provider manual and letter that address the contract language. The MCO should address the specific contract language by asking providers who do not have an EHR to connect to KHIE and to sign up for direct secure messaging services. The current language gives providers the impression they could do one or the other by using "and/or" in the language.	**Anthem Response:** Anthem will review both the provider letter and Provider Manual and update accordingly per the recommendation.
30.2 Prompt Payment of Claims				

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MCO Quality Assessment and Performance Improvement: Health Information Systems (HIS) (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
In accordance with 42 CFR 447.46, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims, including I/T/Us, for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims.	Deem for 2017	Full	The MCO has addressed this requirement. The 2017-2018 Claims Payment_YTD Summary documents summarize that all claims are paid and denied within a 30-day timeframe. In addition to this, a claims lag report was provided at the onsite audit which showed the number of claims received after the month of date of service throughout the audit time period. Onsite, staff stated that the majority of all claims received are auto-adjudicated and that all claims are adjudicated within a 30-day timeframe.	
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended. The date of receipt is the date the MCO receives the claim, as indicated by its date stamp on the claim or other notation as appropriate to the medium used to file a claim and the date of payment is the date of the check or other form of payment.	Deem for 2017 New Requirement	Substantial	The Inventory Management policy and procedure document defines the receipt date to be the date the claim was received. Adjudicated Claims are defined on page 3 of the document but unlike date of receipt, no definition is provided for payment dates or adjudication dates. Additionally, KRS 2015.593 is not referenced in the references section. **Recommendation for Anthem** It is recommended that Anthem include the definition for adjudication date or payment date as well as reference the KRS 2015.593 regulation in an updated policy and procedure document.	**Anthem Response:** Anthem agrees with the finding and is in the process of updating its policies to incorporate the required language.
The Contractor shall notify the requesting provider of any decision to deny a Claim or to authorize a service in an amount, duration, or scope that is less than requested.		Full	The MCO has addressed this requirement. A sample Explanation of Payment (EOP) redacted file was provided to show compliance with this requirement. The EOP detailed payments on the submitted claim and an explanation of	

Final Findings

MCO 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**
			denial to each line submitted. Reference to payments and service authorizations are also present in the provider manual.	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

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	13	1	0	0
Total Points	39	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		**2.93**		

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

Questions:
In review of the technical workgroup meeting minutes some questions:
In what situation do you have unrepairable encounters, and what is the resolution to handling these?

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

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

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
amount beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that a State is able to continue its existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
35.2 Care Management System				
As part of the Care Management System, the Contractor shall employ care coordinators and case managers to arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.	Deemed for 2017	Full	This requirement is addressed in GBD CM Policy 003 Case Manager Assessment April 2017, Section KY Exception, on pages 9–10; 2017 CM Program Description; and in Case Management Job Description.	
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.	Deemed for 2017	Full	Includes review of MCO Report #79 Health Risk Assessments (HRAs; see Quarterly Desk Audit results). This requirement is addressed in the MCO	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Report #79 HRAs; GBD CM Policy-019 CM Program Case Identification_Dec 2016, Sections Identification Sources and Referral Sources on pages 1–2; GBD CM Policy-019 CM Program Case Identification_February 2018, Sections Identification Sources and Referral Sources on pages 1–3; and in 2017 CM Program Description, Section Enterprise Model of Case Management, Identification on pages 8–10.	
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.	Deemed for 2017	Full	This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10 and in 2017 CM Program Description.	
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.	Deemed for 2017	Full	This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9-10.	
35.3 Care Coordination				
The care coordinators and case managers will work with the primary care providers as teams to provide appropriate services for Members.	Deemed for 2017	Full	This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10 and in 2017 CM Program Description.	
Care coordination is a process to assure that the physical and behavioral health needs of Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.	Deemed for 2017	Full	This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10.	
The Contractor shall identify a Member with special physical and behavioral health care needs and shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.	Deemed for 2017	Full	This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10.	
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.		Full	Includes review results for care coordination and complex case management files. This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10. **Care Coordination File Review Results** Ten (10) of 10 care coordination files contained a Care Coordination Assessment (CNA). **Complex Case Management File Review Results** Ten (10) of 10 complex 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**
			files contained a CNA.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.		Full	Includes review results for care coordination and complex case management files. This requirement is addressed in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10; GBD CM Policy-004 CM Monitoring Follow Up and Evaluation Dec 2016; and in GBD CM Policy-004 CM Monitoring Follow Up and Evaluation Sept 2017. **Care Coordination File Review Results** Ten (10) of 10 care coordination files contained a comprehensive assessment. Nine (9) of these 10 files contained a care plan. The 1 file that did not contain a care plan was closed before a care plan could be discussed, because the member's caregiver could not be contacted. This file was deemed not applicable for a care plan. **Complex Case Management File Review Reuslts** Ten (10) of 10 complex case management files contained a comprehensive assessment. All 10 of these files also contained a care plan.	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all	Full - This requirement is addressed in the DCBS Foster	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy in	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DCBS population.	Care Children – KY on page 1.		the Procedure Section.	
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.	Deemed for 2017	Full	This requirement is addressed in Member Handbook 2017; Provider Manual 2017; and in GBD CM 003 Case Manager Assessment April 2017, Section KY Exception on pages 9–10.	
36.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.	Deemed for 2017	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
The Contractor shall have an internal operational process, in accordance with policy and procedure, to	Deemed for 2017	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy;	

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**
target Members for the purpose of screening and identifying ISHCN's.			10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
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.	Deemed for 2017	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: A. Children in/or receiving Foster Care or adoption assistance; B. Blind/Disabled Children under age 19 and Related Populations eligible for SSI; C. Adults over the age of 65; D. Homeless (upon identification); E. Individuals with chronic physical health illnesses; F. Individuals with chronic behavioral health illnesses; G. Children receiving EPSDT Special Services.	Full - This requirement is addressed in the Identification and Assessment of Individuals with Special Healthcare Needs – KY document.	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.	Substantial - This requirement is partially addressed in the AKYPEC-0964-16 HEDIS BH Resource Final brochure. **Recommendation for Anthem** The plan should update its policy to include the necessary distribution of information and	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	

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**
	materials specific to the needs of the member, as appropriate. Anthem should work with the state to define Children with ISHCN and to develop educational materials customized to ISHCN member needs. **MCO Response:** Anthem agrees to findings.			
The Contractor shall have in place policies governing the mechanisms utilized to identify, screen, and assess individuals with special health care needs.	Deemed for 2017	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
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.	Deemed for 2017	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
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.	Deemed for 2017	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
36.2 DCBS and DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN. The Contractor shall attempt to obtain the service plan which will be	October 2017 Review Findings Full This is addressed in the following documents Anthem		Includes review results for DCBS service plan and DCBS claims/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**
completed by DCBS or DAIL. The service plan will used by DCBS and/or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care and Adult Guardianship Cases shall be sent to Department thirty (30) days after the end of each month.	provided: DCBS Staffing DCBS CM Team Meeting 2/15/17 DCBS CM Team Meeting 5/25/17 – MBR PHI REDACTED DCBS CM Team Meeting 7/28/17. Anthem increased its staff in the area and included the Desktop Procedures for staff to follow. <u>DCBS File Review</u> 10 of 10 files met the review requirements for file documentation of ongoing care coordination or referral to Case Management. <u>January 2017 Review Findings</u> Minimal - Includes review results for DCBS Service Plan and DCBS Claims/Case Management files This is addressed in the DCBS Foster Care Children – KY on page 1. <u>DCBS Service Plan and DCBS Claims/Case Management file review</u> 0 of 10 files met the review requirements for file documentation of ongoing care coordination or referral to Case			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Management. Anthem identified a plan to improve performance that included hiring a new Director for Behavioral Health, dedication of 2 full time support staff for initial DCBS contact, and dedication of 1-2 additional case managers; the latter beginning the week of January 17, 2017. **Recommendation for Anthem** The MCO provided verbal and written explanations of barriers and improvement plans, and should continue working with the State and DCBS to implement planned improvements, as well as identify additional approaches identified by the State-MCO-DCBS collaborative workgroup. **MCO Response:** Anthem agrees with finding. Plan for improvement: - Hiring of new Director for Behavioral Health allowing for more leadership and appropriate use of resources with Program			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	Manager to identify and address gaps as they emerge - Dedication of 2 full time support staff to make initial calls to DCBS to: a) verify current DCBS custody, b) get contact information for social worker (foster parent, facility staff, etc.), c) complete initial HRA and request Service Plan d) inform DCBS worker the member will receive case management services from the health plan at a level appropriate to the child's physical and behavioral health needs (all members in DCBS custody will have some level of ongoing care coordination) - Dedicate 1-2 additional Case Managers in addition to the 1 dedicated Case Manager already working with this population to complete case management duties compliant with the contract - Continue to work closely and collaborate with DMS/DCBS through monthly meetings as			

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**
	well as other MCO's as appropriate to eliminate barriers to serving this population. - Case Managers and support staff received updated training on identifying gaps in care (physical and behavioral health) for that member and how to address with DCBS and guardian on 2/3/2017			
36.3 Adult Guardianship Clients				
Each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to determine what level of case management is needed.	Full - This requirement is addressed in the Adult Guardianship Members – KY on page 1.			
36.4 Children in Foster Care				
No less than quarterly, Contractor's staff shall meet with DCBS staff to identify, discuss and resolve any health care issues and needs of the Contractor's Foster Care membership. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.	Full - This requirement is addressed in the Adult Guardianship Members – KY on page 1.			
If DCBS service plan identifies the need for case	October 2017 Review Findings		Includes review results for DCBS 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**
management or DCBS staff requests case management for a Member, the Contractor's staff will work with the foster parent and/or DCBS staff to develop a case management plan.	Full - This is addressed in the following documents Anthem provided: DCBS Staffing DCBS CM Team Meeting 2/15/17 DCBS CM Team Meeting 5/25/17 – MBR PHI REDACTED DCBS CM Team Meeting 7/28/17. Anthem increased its staff in the area and included the Desktop Procedures for staff to follow. <u>DCBS File Review</u> 10 of 10 files met the review requirements. coordination or referral to Case Management. <u>January 2017 Review Findings</u> Minimal - Includes review results for DCBS Service Plan files This requirement is addressed in the DCBS Foster Care Children – KY on page 1. <u>DCBS Service Plan and DCBS Claims/Case Management file review</u> 0 of 10 files met the requirements for coordination with DCBS staff regarding development of the care plan. 9 of 10 files met the review		plan files.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	requirement for file documentation of physician well visits and/or EPSDT services provided. The one file without such documentation did include documentation of outreach attempted via gap reports distributed to provider and member. **Recommendation for Anthem** The MCO provided verbal and written explanations of barriers and improvement plans, and should continue working with the State and DCBS to implement planned improvements, as well as identify additional approaches identified by the State-MCO-DCBS collaborative workgroup. **MCO Response:** Anthem agrees with finding. Plan for improvement: - Hiring of new Director for Behavioral Health allowing for more leadership and appropriate use of resources with Program Manager to identify and address gaps as they emerge			

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**
	- Dedication of 2 full time support staff to make initial calls to DCBS to: a) verify current DCBS custody, b) get contact information for social worker and actual caregiver for the child (foster parent, facility staff, etc.), c) complete initial HRA and request Service Plan d) inform DCBS worker the member will receive case management services from the health plan at a level appropriate to the child's physical and behavioral health needs (all members in DCBS custody will have some level of ongoing care coordination) - Dedicate 1-2 additional Case Managers in addition to the 1 dedicated Case Manager already working with this population to complete case management duties compliant with the contract - Continue to work closely and collaborate with DMS/DCBS through monthly meetings as well as other MCO's as			

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**
	appropriate to eliminate barriers to serving this population. - Case Managers and support staff received updated training on identifying gaps in care (physical and behavioral health) for that member and how to address with DCBS and guardian on 2/3/2017			
The Contractor's staff will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.	<u>October 2017 Review Findings</u> Full - This is addressed in the following documents Anthem provided: DCBS Staffing DCBS CM Team Meeting 2/15/17 DCBS CM Team Meeting 5/25/17 – MBR PHI REDACTED DCBS CM Team Meeting 7/28/17. Anthem increased its staff in the area and included the Desktop Procedures for staff to follow. <u>DCBS File Review</u> 10 of 10 files met the review requirements. Not all cases required a case plan or modification of an existing one. Anthem did make an effort to contact DCBS on all cases for care coordination.		Includes review results for DCBS service plan files.	

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	January 2017 Review Findings Minimal - Includes review results for DCBS Service Plan files This requirement is addressed in the DCBS Foster Care Children – KY on pages 1 and 2. DCBS Service Plan and DCBS Claims/Case Management file review 0 of 10 files met the requirements for consultation with DCBS staff regarding modification of the care plan. **Recommendation for Anthem** The MCO provided verbal and written explanations of barriers and improvement plans, and should continue working with the State and DCBS to implement planned improvements, as well as identify additional approaches identified by the State-MCO-DCBS collaborative workgroup. **MCO Response:** Anthem agrees with finding. Plan for improvement:			

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**
	- Hiring of new Director for Behavioral Health allowing for more leadership and appropriate use of resources with Program Manager to identify and address gaps as they emerge - Dedication of 2 full time support staff to make initial calls to DCBS to: a) verify current DCBS custody, b) get contact information for social worker and actual caregiver for the child (foster parent, facility staff, etc.), c) complete initial HRA and request Service Plan d) inform DCBS worker the member will receive case management services from the health plan at a level appropriate to the child's physical and behavioral health needs (all members in DCBS custody will have some level of ongoing care coordination) - Dedicate 1-2 additional Case Managers in addition to the 1 dedicated Case Manager already working with this population to complete 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**
	duties compliant with the contract - Continue to work closely and collaborate with DMS/DCBS through monthly meetings as well as other MCO's as appropriate to eliminate barriers to serving this population. - Case Managers and support staff received updated training on identifying gaps in care (physical and behavioral health) for that member and how to address with DCBS and guardian on 2/3/2017			
The designated Contractor staff will sign each service plan made available by DCBS to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated Department representative.	Full - This requirement is addressed in the DCBS Foster Care Children – KY on pages 1 and 2.			
The Contractor shall notify the Department and DCBS no later than three (3) business days prior to the decertification of a foster child for services at a hospital or other residential facility located in Kentucky and no later than seven (7) business days prior to the	New Requirement	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy, decertification example and in DCBS desktop6.2018.	

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**
decertification of a foster child for services at a hospital or other residential facility located out of state. Written documentation of an upcoming medical necessity review does not qualify as a decertification notification. The Department shall provide the Contractor with the office or division, the individual(s) and the contact information for such notification and provide updated contact information as necessary.				
The decertification notification shall include: A. the Member name, B. Member ID, C. facility name, D. level of care, E. discharge plan and F. date of next follow-up appointment.	New Requirement	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy; 10_Identification and Assessment of ISHCN-KY Policy; and in the 10_Adult Guardianship Members - KY Policy.	
If the Contractor fails to notify the Department and DCBS at least three (3) business days or seven (7) business days, as applicable, prior to the decertification and the foster child remains in the facility because arrangements for placement cannot be made, the Contractor shall be responsible for the time the foster child remains in the facility prior to notification and up to three (3) business days or seven (7) business days, as applicable, after notification.	New Requirement	Full	This requirement is addressed in the 10_DCBS Foster Care Children- KY Policy.	
The Contractor shall require in its contracts with Providers that the Provider provides basic, targeted or intensive case management services as medically necessary to foster children who are discharged from a hospital or other residential facility. The Contractor, case manager and Provider shall participate in appropriate discharge planning, focused on ensuring that the needed	New Requirement	Full	This requirement is addressed in Anthem Provider Manual 2017, Section 7.10.3 - Coordination of Behavioral Health and Physical Health Treatment; and in the 10_DCBS Foster Care Children- KY Policy.	

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**
supports and services to meet the Member's behavioral and physical health needs will be provided outside of the hospital or other residential facility.				
33. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.	Deem for 2017			
33.8 Pediatric Interface				
School-Based Services provided by school personnel are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid.	Deem for 2017			
Preventive and remedial services as contained in 907 KAR 1:360 and the Kentucky State Medicaid Plan provided by the Department of Public Health through public health departments in schools by a Physician, Physician's Assistant, Advanced Registered Nurse Practitioner, Registered Nurse, or other appropriately supervised health care professional are included in Contractor coverage. Service provided under a child's IEP should not be duplicated. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services to eligible Members.	Deem for 2017			
Services provided under HANDS shall be excluded from Contractor coverage.				
Pediatric Interface Services includes pediatric concurrent	Deemed for 2017			

Final Findings

Case Management/Care Coordination (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
care as mandated by the ACA. The Contractor shall simultaneously provide palliative hospice services in conjunction with curative services and medications for pediatric patients diagnosed with life-threatening/terminal illnesses.				
38.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.	Deemed for 2017		Includes review of MCO Reports #65 Foster Care and #66 Guardianship (see Quarterly Desk Audit results).	

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Case Management/Care Coordination

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	23	0	0	0
Total Points	69	0	0	0

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
Case Management/Care Coordination
Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

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

File Review

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
23.7 Member Rights and Responsibilities				
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.	Deemed for 2017	Full	The 2017 Member Handbook lists member rights and responsibilities on pages 57–61. The 2018 Member Handbook addresses this requirement on pages 62–66.	
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.	Full - The Provider Manual, Section 2.9 on page 25, addresses the component of the requirement concerning out-of-network providers' access to plan policies and procedures. Additionally, Section 3.16, page 40, of the Manual addresses the right of in-network providers to have access to plan policies and procedures.	Full	The 2018 Provider Manual lists member rights and responsibilities within section 3.12. The requirement that out-of-network providers receive access to member rights policies and procedures as requested is addressed within the Member Rights and Responsibilities Policy on page 1.	
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;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 2.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 2.	
C. Consent for or refusal of treatment and active participation in decision choices;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
F. Timely access to care that does not have any communication or physical access barriers;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
I. Timely referral and access to medically indicated specialty care; and	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
K. Any Indian enrolled with the Contractor eligible to receive services from a participating I/T/U provider or a I/T/U primary care provider shall be allowed to receive services from that provider if part of Contractor's network.	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
B. Abide by the Contractor's and Department's policies and procedures;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
C. Become informed about service and treatment	Deemed for 2017	Full	This requirement is addressed in the Member	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
options;			Rights and Responsibilities Policy on page 3.	
D. Actively participate in personal health and care decisions, practice healthy life styles;	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
E. Report suspected Fraud and Abuse; and	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
F. Keep appointments or call to cancel.	Deemed for 2017	Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3.	
23.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. With the exception of a new Member assigned to the Contractor, the Contractor is in compliance with this requirement if the Member's handbook is: A. Mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member. B. Provided by email after obtaining the Member's agreement to receive the information by email; C. Posted on the Contractor's website and the Contractor advises the Member in paper or electronic form that the information is available on the internet and includes the internet address, provided that Member's with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or	New Requirement	Substantial	The mailing time standards for the member handbook are addressed in the Member Rights and Responsibilities Policy on page 2. Section A of the requirement is partially addressed by the Member Rights and Responsibilities Policy on page 2, procedure 2A. The language supporting requirements B through D are not addressed in the Member Rights and Responsibility Policy for the audit time period. The MCO discussed on site that they try to accommodate members with requests for written or oral communications in other languages or formats. Page 82 of the member handbook advises members that interpreters and written materials in other formats (large print, electronic or other versions) are available to members with disabilities or other language speakers at no cost. On site, the handbook was viewed online. The MCO also discussed how materials are shared with members who are visually impaired or deaf.	**Anthem Response:** Anthem has added verbiage to the Member Handbook indicating that it can be provided by email after obtaining the Member's agreement to receive the information by email. The updated draft is in Anthem's internal review and approval process and will then be sent for DMS approval.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
D. Provided by any other method that can reasonably be expected to result in the Member receiving that information.			The MCO provided a new revised draft version of the policy with a review date of September 2018. The draft version includes this language going forward. **Recommendation for MCO** The MCO should communicate with members through the handbook that if they would like to receive an electronic copy of the handbook via email, they may do so as long as they provide a valid email address for outreach and consent to receiving the information by email.	
For any new Member assigned to the Contractor, the Contractor shall mail a hard copy of the Member Handbook within five (5) business days of notification of the assignment.	New Requirement	Full	The Member Rights and Responsibilities Policy addresses the requirement that members are to receive a handbook within the 5 business days of the contractor's receipt of enrollment on page 2.	
If the information is provided electronically, it must be in a format that is readily accessible, is placed in a location on the website that is prominent and easily accessible, can be electronically retained and printed, and that the information is available in paper form without charge upon request within five (5) business days.	New Requirement	Minimal	The member handbook is readily available to Medicaid members online via the MCO's website under the Benefits page in Member Materials, and can be printed as needed. Language informing members who view the online member handbook that the information is available in paper form without charge upon request within 5 business days is missing from the website and the online handbook. **Recommendation for MCO** Language addressing this requirement was not addressed in the policy for the audit timeframe, but has been added to the revised draft of the current policy which has a review date of	**Anthem Response:** The Member Rights and Responsibilities Policy and Procedure draft was updated and approved internally on 9/6/18. The following language will be added to the Anthem member website on the Member Materials page under Member handbooks header: "You can request the member handbook in paper format, which is available without charge upon request within 5 business days, by contacting Member Services at 1 855 690 7784 (TTY 711) Monday through Friday 7 a.m. to 7 p.m." The updated language is currently in review in Anthem's

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			September 2018. The MCO should provide this revised policy for the next review period. Additionally, the MCO should include the information that members can request the member handbook in paper format, which is available without charge upon request within 5 business days, in the online Member Materials webpage where the English and Spanish member handbooks are placed for viewing.	internal review process.
The Member Handbook shall be available in English, Spanish and each prevalent non-English language.	Deemed for 2017 New Requirement	Full	A copy of the English and Spanish versions of the member handbook for 2017 and 2018 were provided. Page 71 of the 2018 Member Handbook states the handbooks are also available in any language spoken by 5% of the enrollee population.	
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.	Deemed for 2017	Full	The MCO demonstrated the location of the handbook on their website.	
The Contractor shall review the handbook at least annually and shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers, covered services and any service not covered by the Contractor because of moral or religious objections. Contractor shall communicate any changes to Members in written form at least thirty (30) days before the intended effective date of the change. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has the authority to review the Contractor's Member Handbook at any time.	Deemed for 2017 New Requirement	Minimal	The Developing and Revising Member Handbooks Policy addresses the requirement that the MCO reviews the handbook on an annual basis. However, the new contract language was not addressed in this policy, but it has been added to the September 2018 drafted version of the Developing and Revising Member Policy. Staff discussed on site, that if any changes affect members, member newsletters are sent to inform them of these updates. Members can refer to the member newsletter for any new updates online as well. Several newsletters for the audit time period were provided for review.	**Anthem Response:** Developing and Revising the Member Handbook policy revisions approved internally with appropriate updates 10/18/18. The following language will be added to the Anthem Member Handbook paper and electronic versions: "Updated Month/Year" This language is currently in Anthem's internal approval process.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			Recommendation for MCO The MCO should include the revision date for the handbook in the paper and online formats, and the revision date should be placed in the title page or somewhere prominent where members can easily view the information. Even if the handbook is reviewed and published annually, there should be continuous updates reflecting current statewide policy; revision dates help members to be aware if handbooks reflect current statewide policies.	
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:	Deemed for 2017	Full	The Developing and Revising Member Handbooks Policy addresses the language that the handbook is written at a sixth-grade reading comprehension level on page 8.	
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;	Deemed for 2017	Full	The member handbooks for 2017 and 2018 on pages 6 and 7, respectively, inform members that the provider directory is included in their enrollment package. The 2017 and 2018 provider directory listings include names, sites and telephone numbers of primary care providers (PCPs) within the MCO's network.	
B. How to access a list of network providers for covered services in paper form, upon request, or electronic form containing information required in 42 CFR 438.10(h);	New Requirement	Full	The member handbooks for 2017 and 2018 on pages 6 and 7, respectively, inform members that the provider directory is included in their enrollment package or members can refer to their online provider directory. In review of the website, members can sign-in and change PCPs or use the Find A Doctor tool. Page 82 of the 2018 Member Handbook includes language that	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			written materials in large print, audio, electronic and other formats are available to members at no cost.	
C. Any restrictions on a Member's freedom of choice among network providers;	New Requirement	Full	This requirement is addressed in the 2018 Member Handbook in the Member Rights Section on page 64. This section states that members can contact the MCO on restrictions on freedom of choice of network providers. As discussed on site, there are no restrictions on freedom of choice for members to access other network providers. If there are panel limitations, the member could refer to the provider directory or call the call center.	
D. The procedures for selecting a PCP and scheduling an initial health appointment or requesting a change of PCP and specialists; reasons for which a request may be denied; and reasons a Provider may request a change;	New Requirement	Full	The 2018 Member Handbook explains the reasons for selecting or changing a PCP on pages 6–9. Information on how to make an appointment with a PCP and if providers ask members to be changed to another PCP is addressed on page 9. Additional information on how to request specialists is discussed on pages 10–11.	
E. The availability of oral interpretation services for all languages, written translations in English, Spanish, and each prevalent non- English language as well as for the top 15 non-English languages as released by the U.S. Department of Health and Human Services, Office for Civil Rights, alternative formats, and other auxiliary aids and services as well as how to access those services;	New Requirement	Substantial	Both English and Spanish editions of the member handbook were provided. Page 31 of the 2018 Member Handbook states that members who do not speak English have access to oral interpretation services. Those who are deaf or hard of hearing can call 711. Qualified sign language interpreters are available at no cost to members. Page 63 of the member handbook states oral interpretation services are available in all	**Anthem Response:** Anthem is in the process of updating its policies and documents to incorporate the required language. Anthem determined the change required to incorporate the additional 3 languages and to ensure all required languages are in compliance.

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			languages, and that the handbook is available in any language spoken by 5% of the enrollee population including Spanish. As discussed on site, for any calls received from members who speak a different language, the MCO has a subcontractor who can help address the additional languages. The MCO discussed that in one instance during the review period where there was no translator available for a particular language request, the MCO found an outside translator to help address the member. The MCO will pay for the translated version for members who need written communication. For those who are visually impaired or deaf, the MCO has TTY. The MCO does not rely on providers to give their own interpretation. The MCO had the majority of the languages listed on the HHS top 15 languages for Kentucky in addition to English and Spanish, except for the following three languages as per their "Babel" documentation: Pennsylvania Dutch, Cushite and Bantu. A vendor attestation from Ingenuiti for language translated material was provided at the onsite audit for the MCO's current materials. **Recommendation for MCO** The MCO should continue to address the languages they've identified through their current process if this methodology has been sufficient in addressing the language needs of their population. However, as per new contract	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			language, The MCO should make reference to the HHS Top 15 languages in their policy and procedure documents as well as incorporate the missing HHS Top 15 listed languages for Kentucky in their member handbook taglines on pages 83–86 and other translated member materials.	
F. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;	Deemed for 2017	Full	The 2017 and 2018 member handbooks list the Member Services number on page 2. The 24/7 Care-on-Call number for members to call if they require medical advice is listed on page 3 of both handbooks. The hours of operation is also listed on page 3 of both handbooks. The address of the MCO is listed on page 5 of both handbooks.	
G. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;	Deemed for 2017	Full	The 2017 and 2018 member handbooks list all covered services in the section titled, "Anthem Covered Services." The MCO includes a statement in this section stating they are liable only for services that have been approved.	
H. Member rights and responsibilities including reporting suspected fraud and abuse;	Deemed for 2017	Full	The 2017 and 2018 member handbooks address this requirement under the section titled, "Your Member Rights and Responsibilities."	
I. Procedures for obtaining Emergency Care and non-emergency care after hours, what constitutes an emergency medical condition, the fact that a prior authorization is not required for emergency services and the right to use any hospital or other setting for emergency care. For a life-threatening situation, instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 911;	Deemed for 2017 New Requirement	Full	The requirement is addressed in both 2017 and 2018 member handbooks. Pages 33–35 in the 2017 handbook and pages 35-38 in the 2018 handbook describe what constitutes an emergency, what members should do in an emergency situation, and that no prior approval is needed for emergency care.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
J. Procedures for obtaining transportation for both emergency and non-emergency situations;	Deemed for 2017	Full	This requirement is addressed in both 2017 and 2018 member handbooks under member's covered services (on pages 4, 5 and 14 of the 2017 handbook, and pages 4, 5 and 26 of the 2018 handbook).	
K. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;	Deemed for 2017	Full	This requirement is addressed in the 2017 and 2018 member handbooks on page 4.	
L. Procedures for arranging EPSDT for persons under the age of 21 years;	Deemed for 2017	Full	For the 2018 Member Handbook, the appropriate timelines for wellness visits for children less than 21 years of age are listed on page vi. Under Covered Services on page 19, the handbook states to call the child's PCP to schedule checkups and screenings.	
M. Procedures for obtaining access to Long Term Care Services;	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 4.	
N. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 4.	
O. A list of direct access services that may be accessed without the authorization of a PCP;	Deemed for 2017	Full	The list of covered services in the 2018 Member Handbook on pages 18–21 includes notes for services that may require prior approval or prior authorization.	
P. Information about how to access care before a PCP is assigned or chosen;	Deemed for 2017	Full	The requirement is addressed in the 2018 Member Handbook in the last sentence on page 6.	
Q. A Member's right to obtain second opinion in or out of the Contractor's Provider network and	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 8.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;				
R. Procedures for obtaining Covered Services from non-network providers;	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 36.	
S. Procedures and timelines for filing a Grievance or Appeal. This shall include the title, address and telephone number of the person responsible for processing and resolving Grievances and Appeals, the availability of assistance in the filing process, the right of the Member to a State Fair Hearing and that benefits will continue while under appeal if MCO decision is to reduce or terminate services;	New Requirement	Minimal	The 2018 Member Handbook discusses grievances and medical appeals on pages 5–57. The title, address and telephone number of the person responsible for processing the grievance or appeal is not listed within the handbook, but is included in the draft for the future version of the handbook. Assistance on the filing process, member's right to a state fair hearing and continuation of benefits in the midst of an appeal are addressed within the Grievance and Appeals Section. In the event a member's service is denied and appealed, the member can receive services, but will be liable for any costs incurred from the service. **Recommendation for MCO** The MCO provided the title, address and telephone number of the person responsible for processing and resolving grievances and appeals in a revised draft version of their current member handbook. The MCO should finalize this draft version of the handbook and communicate with members the updated language in the handbook.	**Anthem Response:** Anthem has updated and approved the Member Handbook AKY-MHB-0014-18 which includes the following language in the Grievance and Appeal section on page 46: "You have the right to ask for and get copies of all documents, records and other information used to make the adverse benefit determination, including any medical or benefit guidelines used. We'll give you copies at no cost. If you need assistance in the grievance or appeal filing process or questions about your appeal rights, please contact: Kory Legel, Anthem Medicaid State Operations Manager 13550 Triton Park Blvd. Louisville, KY 40223 Phone: 502- 619-6822"
T. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook in the renewal of Medicaid benefits discussion on page 66.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
U. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook for Services on pages 33–34.	
V. Information on the availability of health education services;	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 52 by discussing the live support team program, My Advocate; this program delivers maternal health education to members at no cost. Page 57 addresses health education classes and community events available to the member.	
W. Any cost sharing imposed;	New Requirement	Full	There is no specific language describing imposed cost sharing. It was discussed on site with the MCO that there is no cost sharing imposed on members and on page 28 of the member handbook, it states that as an extra benefit, there are no copays. Page 17 to page 28 lists covered services, and situations that may have copays imposed, such as emergency room visits that are not emergencies (page 27) or certain inpatient hospital services (page 21). As stated on page 63 of the handbook, members can get information on Anthem services and any copay requirements from the MCO.	
X. How to exercise an advance directive;	New Requirement	Full	This requirement is addressed in the 2018 Member Handbook on page 59.	
Y. Information deemed mandatory by the Department; and	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 63.	
Z. The availability of care coordination, case management and disease management provided by the Contractor.	Deemed for 2017	Full	Disease management is addressed on page 46, care coordination on pages 31–32 and case management on page 32 of the member	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			handbook.	
31.3 Second Opinions				
At the Member's request, the Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, or arrange for the Member to obtain a second opinion outside the network without cost to the Member. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request a second opinion.	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 8. Upon enrollment, as per the handbook, members should have received a written notice regarding their right to ask for a second opinion for any covered health services. However, at the onsite interview, the MCO explained they do not send a separate notice informing members of their right to a second opinion as it is already explained in the mailed member handbook on page 8; the MCO acknowledged onsite they will remove the verbiage regarding members will receive 'written notice' . The requirement language is addressed in full on page 8 of the member handbook. The Second Opinion Policy also demonstrates compliance with this requirement.	
23.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm Eastern Time (ET). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer for all Contractor programs with the exception of behavioral health. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for	Deemed for 2017	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). Current URAC standards dictate average speed of answer by a live person must be within 30 seconds, and that blockage and abandonment rates be 5% or less. Review of the reports shows the MCO is meeting these standards on average. Call Center Report # 11 shows number of calls by various service lines (member, behavioral health,	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
each individual line separately.			provider, medical advice, pharmacy, dental and vision). For each service line, Report #11 includes the number of calls, abandoned calls, rate of abandoned calls, average speed to answer, highest maximum delay, percent of calls answered on or before the 4th ring, percent of calls receiving a busy signal, and percent of calls answered within 30 seconds. Member calls (as well as other call service lines) are further broken out by total all incoming calls, member-self-service voice portal (24/7 call line), member-general info, member-pharmacy, and member web support. The behavioral health line includes after-hours behavioral health call breakout.	
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).	Deemed for 2017	Full	The 2018 Member Handbook and Telephonic Services Policy states that a toll-free 24/7 system for members to call in for medical advice is available. Staff is comprised of registered nurses.	
The Contractor shall self-report their prior (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.	Deemed for 2017	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). Review of the Call Center Report #11 demonstrates compliance with this requirement.	
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	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Member Handbook on page 5, which informs members that other languages, Braille, or audiotaped versions of the handbook are available upon	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
health education. Member written materials shall be provided and English, Spanish, and each prevalent non-English language. Oral interpretation shall be provided for all non-English languages. The Contractor staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.			request. Page 71 of the handbook discusses how members can receive information in a manner that may be easily understood. Staff stated on site that there are three phone vendors. For members who need written communication, the MCO will pay for the translated version. For those who are visually impaired or deaf, the MCO has TTY. The MCO does not rely on providers to give their own interpretation. As per the Cultural Competency Policy, the MCO trains its staff on matters pertaining to economically disadvantaged and culturally diverse individuals. The provider manual also has a section on cultural competency policies and members' right to receive care without discrimination. The MCO also discussed on site the various company initiatives they do for staff such as cultural diversity month, an annual diversity refresher training, and conducts sensitivity trainings to adhere to the needs of the Medicaid population. As stated in the handbook on page 3, the MCO will offer and pay for an interpreter to assist those who are blind or deaf on doctor visits without charge to member at advanced notice.	
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities	Deemed for 2017	Full	This requirement is addressed by the provider manual's Access and Availability Requirements	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
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.			Section.	
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;	Deemed for 2017	Full	Members are informed via the member handbook, as well as the member portal. Member rights are also shared with providers via the provider manual.	
B. Ensure each Member is free to exercise his or her rights without the Contractor or its Providers treating the Member adversely.	Full - The Provider Manual, page 37, lists the members' rights. The final bullet under "General Member Rights" addresses this Contract requirement fully. Additionally, in the Member Services Functions policy, the requirement is stated nearly verbatim on page 6, letter 'b' under "Kentucky".	Full	This requirement is addressed in the provider manual on page 29 and in the Member Services Policy on page 6.	
C. Guaranteeing each Member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.	Full - This requirement is addressed on page 57 of the Member Handbook, and in the Provider Manual. Additionally, the requirement is stated verbatim on page 6 of the Member Services Functions policy, letter 'c' under "Kentucky".	Full	This requirement is addressed in the Member Services Policy on page 6.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
D. Monitoring the selection and assignment process of PCPs;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
E. Identifying, investigating, and resolving Member Grievances about health care services;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
F. Assisting Members with filing formal Appeals regarding plan determinations;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
G. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the Department;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
H. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
I. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
J. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
K. Explaining or answering any questions regarding the Member Handbook;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 7.	
L. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;	Full - This requirement is addressed on page 7 of the Member Services Functions policy, letter 'l'.	Full	This requirement is addressed in the Member Services Policy on page 7.	
M. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 8.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
N. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 8.	
O. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 8.	
P. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases.	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 8.	
Q. Facilitating access to behavioral health services and pharmaceutical services;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 8.	
R. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 8.	
S. Assisting members in making appointments with Providers and obtaining services. When the	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 9.	

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;				
T. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 9.	
U. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 9.	
V. Facilitating access to Member Health Education Programs;	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 9.	
W. Assisting members in completing the Health Risk Assessment (HRA) upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and	Full - This requirement is addressed on page 8 of the Member Services Functions policy, letter 'w'.	Full	This requirement is addressed in the Member Services Policy on page 9.	
X. The Member Services staff shall be responsible for making an annual report to management about any changes needed in member services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.	Deemed for 2017	Full	This requirement is addressed in the Member Services Policy on page 9.	
31.4 Billing Members for Covered Services				

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Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
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.	Deemed for 2017	Full	This requirement is addressed in the 2018 Provider Manual on page 107 under section 11.12 Billing Requirements.	
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.	Deemed for 2017	Full	This requirement is addressed in the 2018 Provider Manual on page 108 under section 11.13 Client Acknowledgement Statement.	
24.0 Member Selection of Primary Care Provider (PCP)				
24.1 Members Not Required to have a PCP				
Dual Eligible Members, Members who are presumptively eligible, adults for whom the state is appointed guardian, disabled children, and foster care children are not required to have a PCP.	Deemed for 2017	Full	This requirement is addressed in the 2018 Member Handbook on page 6 and in the PCP Selection Assignment Policy on page 11.	
24.2 Member Choice of Primary Care Provider				
Members shall choose or have the Contractor select a	Deemed for 2017			

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
PCP for their medical home.				
The Contractor shall have two processes in place for Members to choose a PCP: A. A process for Members who have SSI coverage but are not Dual Eligible Members; and B. A process for other Members.	Deemed for 2017			
24.6 Primary Care Provider (PCP) Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.	Deemed for 2017	Full	This requirement is addressed in the 2018 Primary Care Provider Selection Assignment Policy on pages 8–9. Members are informed additionally via the 2018 Member Handbook.	
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.	Deemed for 2017	Full	This requirement is addressed in the 2018 Primary Care Provider Selection Assignment Policy on page 11.	
A Member shall have the right to change the PCP ninety (90) days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the same Medicaid Region.	Full - Page 8 of the Member Handbook states "You may change your PCP 90 days after the initial assignment and once a year regardless of reason." Additionally, this requirement is addressed on page 47 of the Provider Manual, under "Procedure for Changing PCPs or Other Providers."	Full	The requirement addressing the member's right to change a PCP within the timeframes and conditions is addressed in the member handbook on page 9. The 2018 Anthem Provider Manual also addresses the contract language regarding other reasons for changing PCPs.	
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	Deemed for 2017	Minimal	Although this requirement is addressed partially by the 2018 PCP Selection Assignment Policy on page 7 (missing language on good cause reasons)	**Anthem Response:** Anthem respectfully requests reconsideration of this finding. The specific language regarding good cause

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
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.			and is stated within the MCO's Member Rights and Responsibilities Policy on page 2, it is not clearly communicated in the member handbook. On page 9 of the 2018 Member Handbook, it states that members may change their PCP once a year regardless of reason. This doesn't address the requirements for good cause as stated in the contract language. **Recommendation for MCO** The MCO should update the member handbook to state members have the right to change a PCP for good cause at any time and to define what the qualifying good causes for PCP change requests are. **Final Review Determination** No change in final determination as the policy is a draft and not finalized during the review period.	reasons and what defines qualifying good causes for PCP change requests is located in the Provider Manual. The document is titled "AKY-PM-0014-17 Provider Manual Update DRAFTno cover.REDLINE", Section 4.3.1 and which was uploaded prior to the onsite visit.
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship Member has not utilized a service within one year of enrollment in the PCP's practice and the PCP has documented unsuccessful contact attempts by mail and phone on at least six (6) separate occasions during the year; or inability to meet the medical needs of the Member.	Deemed for 2017 New Requirement	Minimal	The requirement is partially addressed in the 2018 Provider Manual on page 12. The new contract language regarding disenrollment for member's who have not utilized services within one year of enrollment in the PCP's practice is missing. At the onsite audit, provider contracting staff discussed that members are automatically reassigned in the event that members are not visiting their assigned PCP. Members are still able to visit the previously assigned PCP and are not locked in to the newly assigned PCP. If providers' panel of members has individuals who are automatically reassigned, there may not be an opportunity for providers to reach out to members before members get reassigned and issued a new ID card. There is no	**Anthem Response:** The specific language regarding disenrollment for members who have not utilized services within one year is located in the document titled "AKY-PM-0014-17 Provider Manual Update DRAFT_no cover.REDLINE", Section 2.2.2 and which was uploaded prior to the onsite visit.

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
			documentation nor is it listed in the audited timeframe's process that involves verifying with providers that they have documented at least 6 separate occasions to outreach the member. **Recommendation for MCO** The MCO provided an updated draft version of their provider manual that includes the new contract language. The MCO should finalize this draft version and use it in place of the original manual, and communicate the updates communicated to providers. The MCO should modify their process to verify their providers have 6 separate documented attempts to outreach the member before automatically reassigning the providers' members. **Final Review Determination** No change in final determination as the policy is a draft and not finalized during the review period.	
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.	Deemed for 2017	Full	This requirement is addressed in the 2018 Provider Manual on page 12.	
The initial PCP must serve until the new PCP begins	Deemed for 2017	Full	This requirement is addressed in the 2018	

Final Findings

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Plan's and DMS' Responses and Plan of Action**
serving the Member, barring ethical or legal issues. The Member has the right to a grievance regarding such a transfer. The PCP shall make the change for request in writing. Member may request a PCP change in writing, face to face or via telephone.			Provider Manual on page 12. This requirement is also addressed in the member handbook on page 16, stating that members can continue to see their initial PCP until they pick a new one if requested to do so.	
31.5 Referrals for Services not Covered by Contractor				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the Covered Services provided by the Contractor, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Members for Non-Covered Services that shall provide for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.	Deemed for 2017	Full	This requirement is addressed in the Non-Covered and Cost Effective Alternative Services Policy, March 2018, on page 6.	

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	86	2	5	0
Total Points	258	4	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		**2.87**		

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

Final Findings

Enrollee Rights and Protection: Enrollee Rights

Suggested Evidence

Documents

Policies/Procedures for:

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

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

Reports

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

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.3 Member Education and Outreach				
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to its Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.	Deemed for 2017	Full	This requirement is addressed in the 2017 Marketing Plan for Community Outreach and Homeless Plan, Delivery of Health Education and Services-KY Policy, and in the Kentucky Q2 2018 newsletters.	
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.	Deemed for 2017	Full	The 2017 Marketing Plan for Community Outreach and Homeless Plan addresses homeless outreach. Outreach to the other collaborative partners are mentioned in the July 17-18 Community Outreach Activities Report. Member newsletters, targeted mailings, educational materials, and health education brochures are mentioned in Delivery of Health Education Programs and Services –KY as methods of outreach.	
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.	Deemed for 2017	Full	The July 2017-July 2018 Community Outreach Activities Report lists all outreach initiatives as of September 2018 with the campaign name, topic, event details, regions, audience detail and organizer. The Community Relations Team Salesforce Quick Reference Guide shows that the MCO tracks their initiatives in the Salesforce Platform. Outreach representatives detail all outreach activities, and what they accomplish. Reports can be pulled from the salesforce platform on a daily, weekly or monthly basis; using the reports, staff discusses what initiatives are working.	

Final Findings

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
23.4 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.	Deemed for 2017	Full	The 2017 Marketing Plan for Homeless Outreach describes that it is the MCO's goal to strengthen outreach and engagement activities for homeless and domestic violence advocates and to provide sponsorship opportunities for homeless shelters.	
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.	Deemed for 2017	Full	This requirement is addressed in the 2017 Marketing Plan on page 6, and is also included in the list, July 17-July 18 Community Outreach Activities.	
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.	Deemed for 2017	Full	This requirement is addressed in the 2017 Marketing Community Outreach and Homeless Plan. On site, staff discussed various outreach initiatives, food bank programs and homeless shelter outreach activities they carry out. Members who are domestic abuse victims are not easily identifiable unless they indicate so on their health risk assessment forms. For transportation assistance, the MCO works with the state through their contracted vendors. The MCO also spoke of additional services to help this population that will be implemented in 2019.	
23.5 Member Information Materials				
All written materials provided to Members that are critical to obtaining services, including, at a minimum, marketing materials, new member information, provider directories, handbooks, denial and termination notices,	Deemed for 2017 New Requirement	Substantial	The MCO has policy and procedures in place for member communications and written member materials. However, the policy for member materials that was active during	**Anthem Response:** Anthem agrees with the finding. The Member Materials Appropriateness policy with the revisions mentioned was approved internally on

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**
and grievance and appeal information shall comply with 42 CFR 438.10(d) and 45 CFR 92 unless otherwise specifically addressed in this Contract. The information shall at a minimum:			the time period did not include this contract requirement. A draft of the updated policy was provided on site that shows the requirement has been addressed. **Recommendation for MCO** The MCO provided a draft version of their Member Materials Policy which addresses this requirement. The MCO should finalize and use this policy in place of the original.	10/18/18.
A. Be geared toward persons who read at a sixth-grade level and use easily understood language and format;	New Requirement	Full	This requirement is addressed in the Member Materials Appropriateness Policy on page 11.	
B. Be published in at least a twelve (12) point font size, and available in large print in a font size no smaller than 18 point, except font size requirements shall not apply to Member Identification Cards;	Deemed for 2017 New Requirement	Substantial	This requirement is addressed in the Kentucky Cultural Competency Policy. Prior version of this policy indicates text is written in 14 point font on page 5. The MCO provided an updated draft version of their Cultural Competency Policy which addresses the new requirements. **Recommendation for MCO** The MCO provided a draft version of their Cultural Competency Policy which addresses this requirement. The MCO should finalize and use this policy in place of the original.	**Anthem Response:** Anthem agrees with the finding. The Kentucky Cultural Competency policy with the revisions mentioned was approved internally on 9/21/18.
C. Comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).	Deemed for 2017	Full	This requirement is addressed in the Member Materials Appropriateness Policy on page 11.	
D. Be available through auxiliary aids and services, upon request of the Member at no cost;	Deemed for 2017 New Requirement	Full	Member Materials Appropriateness Policy stated that telecommunication devices for the deaf shall be available, and Braille and audio tapes shall be available for the	

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**
			partially blind and blind members. Additionally, this is communicated to members in the handbook on page 86.	
E. Be available in alternative formats, upon request of the Member at no cost;	New Requirement	Full	This requirement is addressed in the member handbook on page 86 and the Member Materials Policy on page 3.	
F. Be available in English, Spanish and each prevalent non-English language	New Requirement	Full	The Member Materials Appropriateness Policy states that language translation shall be available if 5% of the population in any county speaks a language other than English. Spanish is included and so are taglines in other languages at the end of the member handbook.	
G. Be provided through oral interpretation services for any language;	Deemed for 2017 New Requirement	Full	This requirement is addressed in the Member Materials Policy on page 3. As discussed in the member handbook, member services also offers free oral interpretation services.	
H. Must include taglines in the top 15 non-English languages as released by the U.S. Department of Health and Human Services Office of Civil Rights, as well as large print, explaining the availability of written translation or oral interpretation and the toll-free telephone number of the Contractor's entity providing those services and how to request services.	New Requirement	Full	The member handbook and Member Materials Policy indicates that handbooks are available in any language spoken by 5% of the enrollee population. As discussed in the member handbook, member services also offers free oral interpretation services.	
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.	Deemed for 2017	Full	This requirement is addressed in the Member Materials Appropriateness Policy on page 2.	

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**
29.14 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.	Deemed for 2017 New Requirement	Substantial	The Cultural Competency Policy partially addresses this requirement. Narrative addressing gender, sexual orientation and gender identity is lacking for the audited time period. **Recommendation for MCO** The MCO should include the new contract language regarding gender, sexual orientation and gender identity into the Cultural Competency Policy.	**Anthem Response:** Anthem agrees with the finding. The Kentucky Cultural Competency policy with the revisions mentioned was approved internally on 9/21/18.
The Contractor shall communicate such policies to Subcontractors.	Deemed for 2017	Full	This requirement is addressed in the Cultural Competency Policy on pages 2–3.	

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	15	3	0	0
Total Points	45	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		**2.83**		

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

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

Reports

Reports of outreach activities

KY EQRO ANNUAL REVIEW
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
39.1 Medical Records				
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in the Confidentiality of Records section.	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.	Full - Policy and Procedure Medical Record Requirements – KY, page 3 addresses this requirement. Anthem conducted Chart audits in Q1 and Q2 2016. The MCO provided the 'Use of Medical Records Documentation Form' for capturing chart details, including compliance with HIPAA and security	Full	This requirement is addressed in the following policies/documents: Medical Record Requirements – KY; 2017 Medical Record Review Log; On-Site Visit Confirmation Letter Template; Medical Record Audit Onsite Visit Region 3; Chart Audit Letter Fail Template; Chart Audit Letter Results Template.	

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 as well as guidelines for obesity, diabetes, EPSDT visits, depression, and ADHD. The MCO provided the following documents to meet this requirement: 1 Medical Record Requirements - Privacy and Confidentiality of Medical Records page 10 – 11; 2 MR Documentation Review Log page 1 & 5; 3 Sample Provider Audit results notification letter; 4 Provider Failed letter (template) will be used to have individual meeting with provider to discuss outcome of the audit; and 5 Medical Record Audit Executive Summary.			
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.	Deemed for 2017	Full	This requirement is addressed in the following policies/documents: Anthem Provider Manual 2017 on page 75; Anthem Medicaid Provider Agreement, section 3.5; Kentucky Medicaid Attachment Agreement and Compliance Policy on page 24, section 5.10.	
The Contractor shall have a process to systematically review provider medical	Full - Policy and Procedure Medical Record Requirements – KY addresses this requirement.	Full	This requirement is addressed in the following policies/documents: Medical	

Final Findings

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
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.	Chart audits began in Q4 2015 and continue to be conducted on a quarterly basis during the review period. The MCO provided results of audit reported to providers using Clinical Medical Audit Tool (approved January 2014). Additional documentation was provided as evidence to meet this requirement: 1. Sample Provider Audit notification results letter; 2. Provider failed letter (template) pending will be used to have individual meeting with provider to discuss outcome of the audit; and 3. MR Documentation Review Log - page 1.		Record Requirements – KY; 2017 Medical Record Review Log; On-Site Visit Confirmation Letter Template; Medical Record Audit Onsite Visit Region 3; Chart Audit Letter Fail Template; Chart Audit Letter Results Template.	
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:	Full - The revised Policy and Procedure Medical Record Requirements – KY addresses this requirement on page 4. Chart audits began in Q4 2015 and continue to be conducted on a quarterly basis during the review period. The MCO provided the following documents to meet this requirement: 1 Medical Record Requirements - Privacy and Confidentiality of Medical Records page 10 – 11; 2 MR Documentation Review Log page 1 & 5; 3 Sample Provider Audit results notification	Full	This requirement is addressed in the following: Medical Record Requirements – KY; 2017 Medical Record Review Log; On-Site Visit Confirmation Letter Template; Medical Record Audit Onsite Visit Region 3; Chart Audit Letter Fail Template; Chart Audit Letter Results Template.	

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**
	letter; 4 Provider Failed letter (template) will be used to have individual meeting with provider to discuss outcome of the audit; and 5 Medical Record Audit Executive Summary.			
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;	Full - The revised Policy and Procedure Medical Record Requirements – KY addresses this requirement on page 6. Chart audits began in Q4 2015 and continue to be conducted on a quarterly basis during the review period. The MCO provided the following documents to meet this requirement: 1 Medical Record Requirements - Privacy and Confidentiality of Medical Records page 10 – 11; 2 MR Documentation Review Log page 1 & 5; 3 Sample Provider Audit results notification letter; 4 Provider Failed letter (template) will be used to have individual meeting with provider to discuss outcome of the audit; and 5 Medical Record Audit Executive Summary.	Full	This requirement is addressed in the following: Medical Record Requirements – KY; 2017 Medical Record Review Log; On-Site Visit Confirmation Letter Template; Medical Record Audit Onsite Visit Region 3; Chart Audit Letter Fail Template; Chart Audit Letter Results Template.	
B. Allow for the tracking and trending of individual and plan wide provider performance over time;	Full - The revised Policy and Procedure Medical Record Requirements – KY addresses this requirement on page 6. Chart audits began in Q4 2015 and continue to be conducted on a quarterly basis during the review period.	Full	This requirement is addressed in the following: Medical Record Requirements – KY; 2017 Medical Record Review Log; On-Site Visit Confirmation Letter Template; Medical Record Audit Onsite Visit Region 3; Chart Audit Letter Fail Template; Chart Audit Letter Results Template.	

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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 MCO provided the following documents to meet this requirement: 1 Medical Record Requirements - Privacy and Confidentiality of Medical Records page 10 – 11; 2 MR Documentation Review Log page 1 & 5; 3 Sample Provider Audit results notification letter; 4 Provider Failed letter (template) will be used to have individual meeting with provider to discuss outcome of the audit; and 5 Medical Record Audit Executive Summary.			
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and	Full - The revised Policy and Procedure Medical Record Requirements – KY addresses this requirement on page 6. Chart audits began in Q4 2015 and continue to be conducted on a quarterly basis during the review period. The MCO provided the following documents to meet this requirement: 1 Medical Record Requirements - Privacy and Confidentiality of Medical Records page 10 – 11; 2 MR Documentation Review Log page 1 & 5; 3 Sample Provider Audit results notification letter; 4 Provider Failed letter (template) will be used to have individual meeting with provider to discuss outcome of the audit; and 5 Medical Record Audit Executive Summary.	Full	This requirement is addressed in the following: Medical Record Requirements – KY; 2017 Medical Record Review Log; On-Site Visit Confirmation Letter Template; Medical Record Audit Onsite Visit Region 3; Chart Audit Letter Fail Template; Chart Audit Letter Results Template.	
D. Include mechanism for detecting	Full - The revised Policy and Procedure Medical	Full	This requirement is addressed in the	

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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**
instances of over-utilization, under-utilization, and miss utilization.	Record Requirements – KY addresses this requirement on page 6. Chart audits began in Q4 2015 and continue to be conducted on a quarterly basis during the review period. The MCO provided the following documents to meet this requirement for detecting instances of over-utilization, under-utilization, and miss utilization: 1. DentaQuest Fraud and Abuse Utilization - Review for Government - KY Anthem (i.e., Data *analysis shows high utilization of ADA code D7210;* 2. Screen shot of the Clinical Practice Guidelines (CPGs) Audit; and 3. Screen shot of the Missed Utilization Tracking Log.		following: Medical Record Requirements – KY; and Anthem Kentucky Medicaid Quality Management Program Evaluation 2017.	
28.7 Provider Maintenance of Medical Records				
The Contractor shall require their Providers to maintain Member medical records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care	Deemed for 2017	Full	This requirement is addressed in the following: Medical Record Requirements – KY; and Kentucky Medicaid Medical Record Database Screenshots.	

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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**
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).	Deemed for 2017	Full	This requirement is addressed in the following: Anthem Provider Manual 2017; and Kentucky Member Handbook for Medicaid, revised 12-21-2017.	
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
A. Member/patient identification information, on each page;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
B. Personal/biographical data, including	Deemed for 2017	Full	This requirement is addressed in the	

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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**
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;			Medical Record Requirements – KY Policy.	
C. Date of data entry and date of encounter;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
D. Provider identification by name;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
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);	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
G. Identification of current problems;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	

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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**
I. Documentation of immunizations pursuant to 902 KAR 2:060;		Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
J. Identification and history of nicotine, alcohol use or substance abuse;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
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;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
L. Follow-up visits provided secondary to reports of emergency room care;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
M. Hospital discharge summaries;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
N. Advanced Medical Directives, for adults;	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
O. All written denials of service and the reason for the denial; and	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
A Member's medical record shall include the following minimal detail for individual clinical encounters:	Deemed for 2017			
A. History and physical examination for presenting complaints containing relevant psychological and social	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	

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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**
conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;				
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	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
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.	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements – KY Policy.	
28.8 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.	Deemed for 2017	Full	This requirement is addressed in the following: Medical Record Requirements-KY; Anthem Provider Manual 2017, section 5.3; Medical Record Audit Template 2017 Redacted; and Government Business Division, Case Management Policies and Procedures Advanced Directive (GBD-CM-031).	

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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**
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.	Deemed for 2017	Full	This requirement is addressed in the following: Medical Record Requirements-KY; and Government Business Division, Case Management Policies and Procedures Advanced Directive (GBD-CM-031).	
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.	Deemed for 2017	Full	This requirement is addressed in the following: Medical Record Requirements-KY; Anthem Provider Manual 2017, section 5.3; Medical Record Audit Template 2017 Redacted; Government Business Division, Case Management Policies and Procedures Advanced Directive (GBD-CM-031).	
39.2 Confidentiality of Records				
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in the Health Insurance Portability and Accountability Act section of this contract.	Deemed for 2017	Full	This requirement is addressed in the Medical Record Requirements-KY Policy and Anthem Provider Manual 2017.	

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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 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.	Substantial - The Provider Manual, section 3.10 Health Insurance Portability and Accountability Act, page 31 addresses provisions for assuring confidentiality of services for minors. The MCO provided the draft Provider Manual Version 2.1 dated June 24, 2016 and submitted to Collateral Materials Approval Process (CMAP) on November 16, 2016 which addresses the requirement of how to contact the minor member for any needed follow-up and limitations on telephone or mail contact to the home. However, Anthem did not provide evidence the Provider Manual was approved by CMAP and DHS. **Recommendation for Anthem:** Anthem to ensure the revised Provider Manual is finalized. **MCO Response**: Anthem agrees with finding. Provider Manual has been submitted to DMS for approval. Once approved, it will be posted to the health plan website.	Full	This requirement is addressed in the following Medical Record Requirements-KY Policy and Anthem Provider Manual 2017. The provider manual was finalized and verified by visiting their website where the provider manual was found.	
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.	Deemed for 2017	Full	This requirement is addressed in the following: Anthem Medicaid Provider Agreement, Article 3; and Anthem Medicaid Facility Agreement, Article 3.	
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	Deemed for 2017	Full	This requirement is addressed in the following: Anthem Minimum Necessary Requirements Desktop Procedure; and Anthem Corporate Privacy Policy, Minimum Necessary Requirements.	

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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**
the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.				
41.15 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the Subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as are the Contractor.	Deemed for 2017	Full	This requirement is addressed in the following: Anthem Minimum Necessary Requirements Desktop Procedure; Anthem Corporate Privacy Policy, Minimum Necessary Requirements; and Medical Record Requirements – KY Policy.	

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Medical Records

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

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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

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Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.2 Requirements for Behavioral Health Services				
The Contractor shall engage in behavioral health promotion efforts, psychotropic medication management, suicide prevention and overall person centered treatment approaches, to lower morbidity among Members with SMI and SED, including Members with co-occurring developmental disabilities, substance use disorders and smoking cessation. The Contractor in its design and operation of behavioral health services shall incorporate these core values for Medicaid Members: A. Members have the right to retain the fullest control possible over their behavior health treatment. Behavioral health services shall be responsive, coherently organized, and accessible to those who require behavioral healthcare. B. The Contractor shall provide the most normative care in the least restrictive setting and serve Members in the community to the greatest extent possible. C. The Contractor shall measure Members' satisfaction with the services they receive. D. The Contractor's behavioral health services shall be recovery and resiliency focused.	Substantial - This requirement is partially addressed in the Delivery of Behavioral Health Services document. **Recommendation for Anthem** The plan should update its policy to meet requirements B, C and D. **MCO Response:** Anthem agrees with finding. Plan for Correction: Updated Delivery of Behavioral Health Services policy to clearly outline each of the requirements of the contract was submitted for review on 1/10/17 (see draft attached in documents).	Full	This requirement is addressed in Delivery of Behavioral Health Services including Case Management and Discharge Planning; Member Rights and Responsibilities - KY; Anthem Provider Manual 2017, sections 5.1, 5.4, and 7.4; and in Anthem Member Handbook 2017.	
34.3 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix H.	Deemed for 2017	Full	This requirement is addressed in Delivery of Behavioral Health Services including Case Management and Discharge Planning and in Anthem Provider Manual 2017, section 7.10.	

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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**
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for Behavioral Health Services, the Contractor and its providers shall use the most current version of DSM classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the most current version of DSM.	Deemed for 2017	Full	This requirement is addressed in Delivery of Behavioral Health Services including Case Management and Discharge Planning and in Anthem Provider Manual 2017, sections 7.7 and 7.10.	
Providers shall document DSM diagnosis and assessment/outcome information in the Member's medical record.	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.7.	
34.4 Behavioral Health Provider Network				
The Contractor shall provide access to Psychiatrists, Psychologists, and other behavioral health service providers.	Deemed for 2017	Full	Includes review of MCO Report #12A Geo Access Network Reports & Maps and MCO Report #13 Access & Delivery Network Narrative (see Quarterly Desk Audit results). This requirement is addressed in Anthem Provider Manual 2017, section 7.8; Behavioral Health Services; Access to Behavioral Health Care; Access and Availability; and in MCO Report #13: Access and Delivery Network Narrative, dated 07/30/2018, for the review period 4/1/2018 to 6/30/2018..	
Community Mental Health Centers (CMHCs) shall be offered participation in the Contractor provider network. Other eligible providers of behavioral health services	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8; Behavioral Health Services; Access to Behavioral Health Care; and in Access	

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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**
include Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychological Practitioners, Behavioral Health Multi-Specialty Groups, Behavior Health Services Organizations, Licensed Clinical Social Workers, Certified Family, Youth and Peer Support Providers, Targeted Case Managers and other independently licensed behavioral health professions.			and Availability.	
To the extent that non-psychiatrists and other providers of Behavioral Health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.	Full - This requirement is addressed on page 1 of the Access and Availability policy, page 59 of the Provider manual and page 6 of the Access to Behavioral Healthcare Policy. Evidence in support of this requirement was found in the Geo Access Report.	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8; Behavioral Health Services; and in Access to Behavioral Health Care.	
34.5 Member Access to Behavioral Health Services				
The Contractor shall ensure accessibility and availability of qualified providers to all Members.	Deemed for 2017	Full	This requirement is addressed in Access to Behavioral Health Care and in 2017 Behavioral Health Quality Management Program Description Final.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services. The Member Manual shall contain information for Members on how to direct their behavioral health care, as appropriate.	Deemed for 2017	Full	This requirement is addressed in Kentucky Importance of Behavioral Health Collaboration Brochure; Kentucky Medicaid Member Newsletter 2018; and in Anthem Member Handbook 2017.	
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-	Deemed for 2017	Full	This requirement is addressed in Delivery of Behavioral Health Services including CM and Discharge Planning; Member Rights and Responsibilities - KY;	

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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**
network Providers with relevant experience.			and in Anthem Member Handbook 2017.	
34.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Commonwealth.	Full - This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document.	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline; Behavioral Health Telephonic Intake Protocol For Members; and in Anthem Member Handbook 2017.	
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.	Full - This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document.	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.	Full - This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document.	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
The Behavioral Health Services Hotline shall not be answered by any automated means.	Full - Includes placing a call to the BH Services Hotline to confirm that hotline is not answered by any automated means A test call to the Behavioral Health Services Hotline after hours provided evidence in support of implementation of this requirement.	Full	The IPRO reviewer placed a call to the Behavioral Health Services Hotline. It was answered by a person. This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
The Contractor shall ensure that the toll-free Behavioral	Full - Includes review of MCO Report #11 Call	Full	Includes review of MCO Report #11 Call	

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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 Hotline meets the following minimum performance requirements for all Contractor Programs:	Center (see Quarterly Desk Audit results) This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document and the MCO Report #11 Call Center document.		Center (see Quarterly Desk Audit results).. This requirement is addressed in Behavioral Health Emergency Care including Hotline; Behavioral Health Telephonic Intake Protocol For Members; 2017 Utilization Management Program Description Final; and in several examples of Report #11 from the MCO.	
A. Ninety-nine percent (99%) of calls are answered by the fourth ring;	Full - Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document and the MCO Report #11 Call Center document.	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). This requirement is addressed in Behavioral Health Emergency Care including Hotline; Behavioral Health Telephonic Intake Protocol For Members; and in several examples of Report #11 from the MCO.	
B. No incoming calls receive a busy signal;	Full - Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results) This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document and the of MCO Report #11 Call Center document.	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). This requirement is addressed in Behavioral Health Emergency Care including Hotline; Behavioral Health Telephonic Intake Protocol For Members; and in several examples of Report #11 from the 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**
C. The call abandonment rate is seven percent (7%) or less; and	Deemed for 2017	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). This requirement is addressed in Behavioral Health Emergency Care including Hotline; Behavioral Health Telephonic Intake Protocol For Members; and in several examples of Report #11 from the MCO.	
D. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.	Full - This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document.	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
The Contractor may operate one hotline to handle emergency and crisis calls.	Deemed for 2017	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
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.	Deemed for 2017	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.	Deemed for 2017	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs.	Deemed for 2017	Full	This requirement is addressed in Behavioral Health Emergency Care including Hotline and in Behavioral Health Telephonic Intake Protocol For Members.	
The Contractor shall conduct on-going quality assurance to ensure these standards are met.	Deemed for 2017	Full	This requirement is addressed in several examples of Report # 11 from the MCO.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.	Deemed for 2017	Full	Includes review of MCO Report #11 Call Center (see Quarterly Desk Audit results). This requirement is addressed in several examples of Report 11 from the MCO.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractor is responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
34.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice. Such contract provisions and screening and evaluation procedures shall be submitted to the Department for approval.	Full - This requirement is addressed in the Behavioral Health Telephonic Intake Protocol For Members document. Evidence in support of this requirement was found in the Medicaid Provider Bulletin sent to PCPs regarding SBIRT, dated November 28, 2016.	Full	This requirement is addressed in Behavioral Health Telephonic Intake Protocol For Members; Kentucky Importance of Behavioral Health Collaboration Brochure; and in Anthem Provider Manual 2017, section 7.6.	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall provide training to network PCPs on how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.	Deemed for 2017	Full	This requirement is addressed in Kentucky Behavioral Health Services Training PowerPoint FINAL V2 for provider training; Invitation Kentucky Behavioral Health FINAL invitation to training using the PowerPoint presentation; and in Kentucky Medicaid Physical Health and Behavioral Health Collaborative Care Bulletin sent to providers.	
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.	Substantial - This requirement is addressed in the Coordination of Care Between Physical and BH Providers document. BH/PH Care Coordination File Review Results 10 files were reviewed for BH/PH care coordination. 8/9 applicable files (i.e., contacted and consented) had a comprehensive assessment documented. 6/6 applicable files had a care plan. Of the 4 files that were not applicable, 3/4 were not applicable due to unsuccessful member outreach and 1 due to BH specialized care plan for Recovery Resiliency, only. 10/10 files met the requirement for BH/PH care coordination. 9/9 applicable files (member hospitalized) met the requirement for discharge planning documentation. **Recommendation for Anthem** Anthem should ensure that all members receive	Substantial	Includes behavioral health/physical health (BH/PH) care coordination file review summary results. This requirement is addressed in Clinical Coordination Between Physical and BH Providers on pages 4-5; the Coordination of Care Between Behavioral Health and Medical Management Policy on pages 6–7; and in Anthem Provider Manual 2017, section 7.10.3, Coordination of Behavioral Health and Physical Health Treatment. **BH/PH Care Coordination File Review** Seven (7) of 10 files included a comprehensive assessment. The other three files did not. IPRO requested the comprehensive assessments for these files from Anthem, but we did not receive them.	**Anthem Response:** Anthem finds that although the system case notes/history information required to demonstrate the actions meet full compliance, the documentation provided to support compliance was not fully provided to IPRO.

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
	a comprehensive assessment. **MCO Response:** Anthem agrees with finding. Plan of correction: Case Managers for BH and PH teams will receive updated training on timeframes and mandatory completion of Comprehensive Assessment for all members engaged in Case Management or documentation as to why the assessment was not able to be completed when scheduled (joint training scheduled for 4/28/2017)		Ten (10) of 10 files included a care plan. Nine (9) of 10 files included identification of the BH and PH needs of the member and facilitation/ coordination of services. For 1 of 10 files, this requirement was not applicable, because the member did not have any case management needs. Four (4) of 10 files included a case manager and other BH service providers who participated in discharge planning. For the other 6 files, this requirement was not applicable. These 6 members had not been hospitalized; therefore they did not need discharge planning.	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.	Full - This requirement is addressed in the Coordination of Care Between Physical and BH Providers document.	Full	This requirement is addressed in Clinical Coordination Between Physical and Behavioral Health Providers on pages 4–5; the Coordination of Care Between Behavioral Health and Medical Management Policy on pages 6–7; and in Anthem Provider Manual 2017, section 7.10.3, Coordination of Behavioral Health and Physical Health Treatment.	
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members'	Deemed for 2017	Full	This requirement is addressed in Clinical Coordination Between Physical and Behavioral Health Providers on page 5;	

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
behavioral health 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.			and in Anthem Provider Manual 2017, section 7.10.3, Coordination of Behavioral Health and Physical Health Treatment.	
34.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient behavioral health services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, sections 2.5, Primary Care Provider Access and Availability, and section 7.10.2, Responsibilities of Behavioral Health Providers - Behavioral Health Access to Care Standards; the Access and Availability Policy on page 6; and in the Delivery of Behavioral Health Services including Case Management and Discharge Planning Policy on pages 7–8.	
The outpatient treatment must occur within seven (7) days from the date of discharge.	Full - This requirement is addressed in the NET 1 Access and Availability - KY (2) document.	Full	This requirement is addressed in Anthem Provider Manual 2017, sections 2.5, Primary Care Provider Access and Availability and section 7.10.2, Responsibilities of Behavioral Health Providers - Behavioral Health Access to Care Standards; the Access and Availability Policy on page 6; and in Delivery of Behavioral Health Services including Case Management and Discharge Planning Policy on pages 7-8.	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section	

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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**
appointment within twenty-four (24) hours to reschedule appointments.			7.7, Member Records and Treatment Planning.	
34.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.	Full - This requirement is addressed in the Court Ordered Services – KY document.			
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Full - This requirement is addressed in the Court Ordered Services – KY document.			
34.10 Continuity of Care Upon Discharge From a Psychiatric Hospital				
A. The Contractor shall coordinate with providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law and/or voluntarily admitted	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8, Community Provider Requirements; and in Delivery of Behavioral Health Services including Case Management and Discharge Planning on pages 7–8.	

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**
to the state psychiatric hospital.				
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.	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8, Community Provider Requirements.	
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.	Deemed for 2017	Full	The MCO provided lists of employees and dates of meetings at Western, Central, and Eastern State Hospitals, as well as at the Appalachian Regional Hospital as evidence of compliance with this requirement	
B. The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide basic, targeted or intensive case management services as medically necessary to Members with severe mental illness (SMI) and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with SMI.	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8, Community Provider Requirements.	
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	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8, Community Provider Requirements.	

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**
environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.				
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 - This requirement is addressed on page 5 of the Delivery of Behavioral Health Services policy and on page 6 of the Access and Availability Policy. The 2016 Workplan does show improvement in the 7-day follow-up rate from 2015 to 2016, i.e., from 20.52% to 23.54%, and in the 30 day follow-up rate, i.e., from 37.02% to 42.98%; however, rates are still below the 50th percentile. **Recommendation for Anthem** The 2017 Workplan should identify barriers to post-discharge follow-up and interventions to address barriers. **MCO Response:** Anthem agrees to findings.	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.8, Community Provider Requirements; and in the Delivery of Behavioral Health Services including Case Management and Discharge Planning Policy in pages 7–8.	
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.	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.9, Psychotropic Medications.	
34.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:	Deemed for 2017			

Final Findings

Behavioral Health Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);	Deemed for 2017	Full	This requirement is addressed in Behavioral Health Telephonic Intake Protocol for Members on pages 1–4 and 7–8; Access to Behavioral Health Care; Clinical Coordination between Physical and Behavioral Health Providers on pages 1–2 and 4–5; and in Coordination of Care Between Behavioral Health and Medical Management on pages 1–4 and 6–8.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 7.10.3, Coordination of Behavioral Health and Physical Health Treatment; and in the Primary Care Providers and Behavioral Providers: Working Together to Treat the Whole Person Brochure. Also, the MCO maintains Patient 360, a secure website that allows providers to access member information regarding pharmacy prescriptions, prescriber, and quantity.	
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;	Substantial - Evidence in support of this requirement was provided in the CAHPS Survey. The BH/SMI PIP and the PIP for Safe/Judicious use of antipsychotics in children include interventions that address communication of CM with both PH and BH providers; however, interventions and intervention tracking measures to specifically evaluate member-	Full	This requirement is addressed in Serious Mental Illness Performance Improvement Project Final Report; Behavioral Health Collaborative Antipsychotic Medication Performance Improvement Project Final Report; and in the document named Quality review example.	

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**
	approved communication between BH and PCP providers are lacking. **Recommendation for Anthem** Add at least one intervention and quarterly intervention tracking measure, each, to the BH/SMI PIP and to the Antipsychotic Medication PIP. **MCO Response:** Anthem agrees to findings.			
D. Protect the confidentiality of Member information and records; and	Deemed for 2017	Full	This requirement is addressed in Anthem Provider Manual 2017, section 3.7, Health Insurance Portability and Accountability Act.	
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.	Deemed for 2017	Full	This requirement is addressed in Anthem Behavioral Health 2017 Medicaid 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
October 2018
Period of Review: July 1, 2017 – June 30, 2018
MCO: Anthem Blue Cross Blue Shield Medicaid

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	44	1	0	0
Total Points	132	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		**2.98**		

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

Reviewer Decision:

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

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

Final Findings

Behavioral Health Services

Suggested Evidence

Documents

Policies/procedures for:

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

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

Final Findings

Reports

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

File Review

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

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
32.1 Pharmacy General Requirements				
The Contractor shall administer pharmacy benefits in accordance with this section, other requirements specified in this contract, and in accordance with all applicable State and Federal laws and regulations. In accordance with the Contractor's Formulary and/or Preferred Drug List, the Contractor shall provide coverage for all medically necessary legend and non-legend drugs once a drug becomes FDA approved and eligible for manufacturer federal rebates in accordance with Section 1927 of the Social Security Act, and ensure the availability of quality pharmacy services for all enrollees. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) claims processing services with prospective drug utilization review (ProDUR) and edits;	Deemed for 2017	Full	This requirement is addressed in the A02 Drug Use Evaluation Policy.	
B. An accounts receivable (A/R) process that includes records for the Department to systematically track adjustments, recoupments, manual payments, and other required identifying A/R and claim information;	Deemed for 2017	Minimal	This requirement is partially addressed in the ADJ-01 Medicaid Adjustments Policy; however, recoupments, manual payments, and other required identifying accounts receivable (A/R) and claim information had no documentation. **Recommendations for MCO** The MCO should include recoupments, manual payments,	**Anthem Response:** Anthem respectfully requests reconsideration of this finding. This specific language is located in the Policy titled "A16 Health Plan Pharmacy Benefits," Exhibit G, page 58, B. This document was submitted prior to the onsite. Anthem also submitted the "ESI Electronic Claims Adjudication Process Overview" prior to the onsite which also addresses this language.

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			and other required identifying A/R and claim information in their policy. **Final Determination** No change in final determination. IPRO reviewed Anthem's response and referenced documentation. The policy has the exact language but is lacking in an actual process for recoupments, manual payments, and other required identifying A/R and claim information.	
C. Retrospective drug utilization review (RetroDUR) services;	Deemed for 2017	Full	This requirement is addressed in the A02 Drug Use Evaluation Policy.	
D. Formulary and non-formulary services, including but not limited to, prior authorization (PA) services, a PA escalation process and procedure, an appeals process, and a Pharmacy and Therapeutics Committee (P&T);	Deemed for 2017	Full	This requirement is addressed in the A02 Drug Use Evaluation Policy.	
E. Pharmacy Provider relations and education, and call center services (member and provider), in addition to provider services specified elsewhere;	Deemed for 2017	Full	This requirement is addressed in the A08 Pharmacy Prior Authorization Policy.	
F. Seamless interfaces with the information systems of the Department and as needed, any related vendors;	Deemed for 2017	Full	This requirement is addressed in the A60 Quality Process for Maintaining Accurate and Current Pharmacy Benefit Information on Health Plan Member Web Portals.	

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**
G. Claims payment services;	Deemed for 2017	Full	This requirement is addressed in the 2017-2018 Claims Payment YTD Summary.	
H. Reporting and analysis to assist in monitoring and managing the pharmacy program and ensuring compliance with all Federal and State requirements;	Deemed for 2017	Full	This requirement is addressed in the A65 Pharmacy Services PBM Performance Oversight Process.	

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**
I. Assisting the Department by cooperating and providing support during internal and external audits, including CMS certification or reviews, or transitions or upgrades of any MMIS/MEMS systems; and	Substantial - This requirement is addressed in the Pharmacy Benefit Manager Performance Oversight policy. On-site, Anthem explained that the plan's Pharmacy staff participates in weekly calls with the IT department to discuss file transitions and validations, as required for system changes pertinent to the State, e.g., assisting with the validation process. In addition, the pharmacy department assists the regulatory team with updates to State databases, such as KYMMIS, as requested. One specific KYMMIS/MEMS function that the Pharmacy Department is directly responsible for is to maintain the preferred drug list. The policy for Corrective Action-Regulatory Audits supports that the plan adheres to the requirements for addressing noncompliant items identified by audits such as those conducted by CMS and DMS; however, it is either Plan Compliance or Regulatory that submits the formal response to the notice of corrective action, rather than the Pharmacy Department. **Recommendation for Anthem** Meet with DMS to discern specific State expectations for pharmacy's participation with regard to this requirement and incorporate the agreed upon procedures into the relevant policy/procedure document. **MCO Response:** Anthem agrees to findings.	Non-Compliance	No documentation was provided that meets this requirement. **Final Determination** No change in final determination. IPRO reviewed Anthem's response and referenced documentation. The policy has the exact language but is lacking in an actual process (agenda and minutes are a discussion of a topic and not a policy for a process).	**Anthem Response:** Anthem respectfully requests reconsideration of this finding. This specific language is located in the Policy titled "A16 Health Plan Pharmacy Benefits," Exhibit G, page 58, Section 32.1 – Pharmacy General Requirements. This document was submitted prior to the onsite. Anthem also provided the following documents at the time of the audit on 10/17/2018 which supports the requirement: **PPOC Minutes:** Anthem provided a zip file titled *"PPOC Agenda Minutes"* prior to the onsite. Pharmacy Performance Oversight Council ("PPOC"): PPOC monitors the overall performance of all delegated functions related to providing pharmacy operational/clinical service solutions to Anthem members, and ensures delegates' performance meets all applicable Anthem, regulatory and accreditation standards (i.e. NCQA, CMS, URAC, state and federal regulations and requirements). The following Policies and documents support each MMIS Medicaid business function:

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Pursuant to Section 1903(i) of the Social Security Act, all handwritten or computer generated/printed Medicaid prescriptions shall require one or more approved industry-recognized tamper-resistant features to prevent all three (3) of the following: 1. Copying of a completed or blank prescription form; 2. Erasure or modification of information written on the prescription pad by the prescriber; AND 3. Use of counterfeit prescription forms. This requirement does not pertain to prescriptions received by fax, telephone, or electronically.	New Requirement	Full	This requirement is addressed in the ESI Net Pro Manual External – Tamper Resistant.	**Administrative program and cost control:** Includes Anthem's formulary management, Anthem's P&T, and DUR processes at them: *Kentucky_PDL_English* *Anthem PT Process Charter FINAL –02-16-18* *A02- Drug Use Evaluation* *CLININTC-03-74 f14 – Concurrent Drug Utilizers* **Beneficiary and provider inquiries and services:** Includes policies demonstrating how Anthem ensures member and provider Access and to the Pharmacy program and ensures accurate pharmacy information is maintained. *Provider & Member zip file* **Operations of claims control and computer capabilities** Anthem's PBM is delegated to perform pharmacy claims processing: One hundred percent of retail pharmacies that participate in Express Scripts' retail networks are contractually obligated to submit claims electronically through the system; of the claims received, 99.9% are processed electronically at the point of sale. The system allows participating pharmacies to submit prescription drug claims to Express Scripts electronically, 24 hours a

Final Findings

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				day, seven days a week. *ESI_Electronic_Claims Adjudication Process* *ESI Network Provider Manual External Claim* *Medicaid-ADJ-01 Medicaid Adjustment* **Management reporting for planning and control includes:** **Process for verifying the accuracy and completeness of provider and vendor reported data** *PPOC Minutes:* Pharmacy Performance Oversight Council ("PPOC"): PPOC monitors the overall performance of all delegated functions related to providing pharmacy operational/clinical service solutions to Anthem members, and ensures delegates' performance meets all applicable Anthem, regulatory and accreditation standards (i.e. NCQA, CMS, URAC, state and federal regulations and requirements) **Process for screening data for completeness, logic and consistency:** Medicaid RX Encounters PBM Process (this document was submitted at the onsite and was embedded in "#16 Tool Pharmacy Benefits – onsite clarification with embedded documents) **Evidence of timely and accurate reporting of encounter data to DMS:**

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**
				Medicaid RX Encounters PBM Process (this document was submitted at the onsite and was embedded in "#16 Tool Pharmacy Benefits – onsite clarification with embedded documents) **Process for monitoring compliance with claims payment timeliness requirements:** *2017-2018 Claims Payment YTD Summary* **Process for tracking and reporting erred encounter records:** Medicaid RX Encounters PBM Process (this document was submitted at the onsite and was embedded in "#16 Tool Pharmacy Benefits – onsite clarification with embedded documents) **Claim Payment Timeliness Monitoring** *2017-2018 Claims Payment YTD Summary* **Encounters Data Submission Oversight** Medicaid RX Encounters PBM Process (this document was submitted at the onsite and was embedded in "#16 Tool Pharmacy Benefits – onsite clarification with embedded documents)
32.5 Formulary and/or Preferred Drug List				
The Contractor shall maintain a drug formulary and/or preferred drug list (PDL) which follows the general and minimum requirements herein:				

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**
A. The formulary and/or PDLshall: 1) Be made available to Providers and Members, including the tier for each medication and other information as necessary; 2) Only exclude coverage of drugs or drug categories permitted under Section 1927(d) of the Social Security Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1993; 3) Be developed by a P&T that shall represent the enrollees including those with special needs; 4) For each therapeutic drug class, the selection of drugs included shall be sufficient to ensure the availability of covered drugs with the least need for prior authorization; and 5) Not be used for the sole purpose to deny coverage of any Medicaid covered outpatient drug. 6) Be reviewed on a rolling basis so that all represented classes are reviewed within at least a three (3) year period.	New Requirement	Full	1) This requirement is addressed in the Pharmacy _Kentucky Providers – Anthem BCBS Policy and the Member Pharmacy Benefits – Anthem Kentucky Medicaid Policy. 2) No documentation was provided that meets this requirement. 3) This requirement is addressed in Anthem PT Process Charter_Final. 4) This requirement is addressed in Anthem PT Process Charter_Final. 5) This requirement is addressed in Anthem PT Process Charter_Final. 6) This requirement is addressed in Anthem PT Process Charter_Final. **Final Determination** After further review of the referenced documentation this determination is changed to Full	**Anthem Response:** Anthem respectfully requests reconsideration of this finding, This specific language, for #2, is located in the Policy titled "A16 Health Plan Pharmacy Benefits," Exhibit G, page 60, Section 32.5 – Formulary and/or Preferred Drug List. This document was submitted prior to the onsite.
B. If the formulary and/or PDL prefers generic equivalents, Contractor shall provide a brand name exception process for prescribers to use when medically necessary.	New Requirement	Full	This requirement is addressed in the A08 Prior Authorization Process.	

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**
C. Publication of formulary and/or PDL: 1) Contractor shall publish and make available via hard copy upon request, online/webpage or web portal, or by other relevant means of communication its current formulary and/or PDL to all Providers and Members. 2) Formulary and/or PDL drug lists shall be made available on Contractor's web site in a machine readable file and format as specified in 42 CFRC.F.R. section 438.10. 3) The formulary and/or PDL shall be updated by the Contractor throughout the year and shall reflect changes such as, status of a drug, adds or deletes. Updates to the formulary and/or PDL shall be distributed in the formats herein mentioned no later than the effective date of changes.	New Requirement	Full	This requirement is addressed on the MCO's website page for Kentucky Providers/Formularies and the member pharmacy benefits page on the MCO's Kentucky Medicaid website.	
32.4 Pharmacy and Therapeutics Committee				
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T) in accordance with KAR Title 907. The P&T shall meet in Kentucky periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the PDL or drug formulary. The P&T shall be considered an advisory committee to a public body thereby making it subject to Kentucky's Open Meetings Law. Prior to each new calendar year, the Contractor shall give notice to the Department of the time, date and	Deemed for 2017			

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**
location of the P&T meetings.				
32.7 Pharmacy Claims Payment Administration				
The Contractor shall: Process, adjudicate, and pay Kentucky Medicaid pharmacy claims, including voids and full or partial adjustments, via an online, real-time POS system by:	Deemed for 2017			
32.6 Pharmacy Drug Rebate Administration				
The Affordable Care Act requires states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information on drugs and diabetic supplies, including J-code conversions consistent with CMS requirements. The Department or its designated contractor will provide this claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	Deemed for 2017	Non-Compliance	No documentation was provided that meets this requirement.	**Anthem Response:** Anthem agrees with the finding. Anthem will create a Drug Manufacturer Dispute Resolution Policy by January 31, 2019 related to the process to assist DMS with drug manufacturer disputes.

Final Findings

Pharmacy Benefits

Scoring Grid:

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

Overall Compliance Determination:

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

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

Reviewer Decision:

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

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

Final Findings
Pharmacy Benefits
Suggested Evidence

Documents

Policies/procedures for:

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

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

Reports

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