Appendix A

Appendix A – Documentation Submitted for Review

Anthem Blue Cross and Blue Shield

9 Binders
-Evidence of Corrective Actions for Deficiency Areas from the 2005 Review Process
-Compliance to the Federal Medicaid MC Reg. General Information A-F
-Compliance to Federal Reg. General Information G
-General Information, Quality Assessment and Performance Improvement Plans- G
-Compliance to Federal Regulations General Info. H-O
-QAPI 438.240 P
-Clinical Practice Guidelines 438.236 P
-Compliance to Federal Regulations General Information Q-Z

Compliance to Federal Medicaid Managed Care Regulations-
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1. **General Information**
   a. Organization strategic plan, goals and objectives for 2005 and 2006

2. **Record Review**
   a. Listing of practitioners who have been terminated during the credentialing/recredentialing process during calendar year 2005
   b. Listing of all members by diagnoses, who have been case managed or disease managed by CM/DM category from October 1, 2005 through December 31, 2005, and
   c. Appeals and grievance tracking logs or other monitoring tracking process listing records by reason of denial and category of grievance or appeal for CY 2005

3. **V-PM**

4. **PIP**

5. **Quality Assessment and Performance Improvement**

   a. List of all medical record chart review topics, including any for vendor access and timeliness
   b. Provider and service planning documents
   c. Provider network planning documents and GeoAccess reports
   d. Credentialing minutes from CY 2005
   e. Credentialing statistics include number of providers credentialed and in process
   f. Copies of any provider profiling tools or reports
   g. Copies of monitoring and tracking process validating member access to care and services
   h. Provider selection criteria
   i. Provider self reports of appointment and in office waiting times
   j. Provider newsletters, bulletins or other forms of communication to providers
   k. Member handbook
   l. Member needs assessments related to QAPI/network adequacy
   m. Satisfaction surveys of members reflecting results related to QAPI
   n. Minutes and/or other documentation of actions addressing analysis of member complaints and grievances
   o. Access/availability studies results
   p. QM and UM program descriptions, work plans and annual evaluations
   q. QM/DM program description (if separate from above descriptions)
   r. QM minutes indicating areas discussing issues, quality projects, integration of vendors

s. Provide copies of P&Ps that demonstrate that the MCO coordinates the services furnished to he member with the services the member receives from any other MCO, Behavioral Health Care Organization, or Prepaid Inpatient Health Plan
t. Annual utilization statistical report for CY 2005, including, but not limited to, case mix analysis, hospitalization, skilled nursing facility, home health, and emergency/urgent care utilization statistics
u. Annual report of statistics for any call center operations including monthly call volume, average speed to answer and abandonment rate
v. Grievance files or aggregate data related to payment/non payment for services
w. List of required educational topics/programs for staff in QM, UM, DM, member services, provider relations/credentialing, and grievance appeals
x. Processes to determine eligibility for HUSKY Plus programs
y. HUSKY B member referrals to HUSKY Plus, include P&Ps and tracking information
z. P&Ps and tracking demonstrating coordination of referral process for HUSKY Plus members
aa. Documentation defining quality measurement processes, results and tracking for HUSKY B members
bb. documentation of coordination and reporting submitted to the State related to utilization of HUSKY Plus
cc. P&Ps for billing and collecting HUSKY B premium
dd. P&Ps and tracing of HUSKY B annual aggregate cost sharing limit, co-payment, and repayment processes

6. Grievance Systems

a. Results of data collection and analysis to monitor complaints, grievances, or requests to change providers
b. UM and QM committee meeting minutes or task force groups demonstration discussions related to grievance, appeals and complaints
c. Appeals and grievance tracking logs
d. Concerns and complaint tracking, resultant interventions and follow-up demonstrated in minutes, etc.

7. Corrective Action Plan Implementation

a. Documentation describing implementation of corrective actions, including but not limited to policies and procedures, communications to staff, members, providers and vendors, new reports, new job descriptions and education materials.

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Anthem Blue Cross and Blue Shield-2006 Compliance to Federal Regulations
General Information, Quality Assessment and Performance Improvement Plans, Provider Network Analysis

Section I- Copies of Monitoring and tracking validating member access to care and services

- Dec 05-Jan 05-Provider Network Analysis

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General Information
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H- Provider selection criteria

I- Provider self-reports of appointments and in-office wait times, 438.206

J- Provider newsletters, bulletins, or other forms of communications to providers, 428.240

K- Member handbooks; 438.100, 428.236

L- Member needs assessments related to QAPI/network adequacy, etc; 439.206, 438.207

M- Satisfaction surveys of members reflecting results related to QAPI

N-Separate binder for Medicaid Grievance/Appeals

O-Access/availability studies' results; 438.207

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2006 Compliance to Federal Regulations General Information- G

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Section I- Basic Information on Dental Benefit Providers
- Members Rights Statement
- 2005 Dental Benefit Providers Inc. Annual Review with Findings

Section II- LogistiCare
- Policy and Procedure Manual
- Corrective Action Plans
- 2006 Annual Evaluation Findings

OptiCare Eye Health
- Anthem East Annual Evaluation Findings 2006

Well Point Dental Services, Inc.
- Anthem East Annual Evaluation Findings 2006

ValueOptions
- 2005 Annual Oversight Review and Findings of ValueOptions

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Evidence of Corrective Actions for Deficiency Areas from the 2005 Review Process

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-Enrollee Rights and Protection

-Compliance with Standards for Timelines and Access to Services

-Dental Benefit Providers
    -Cities meeting the access standard

-OptiCare Geo Access Report 2005, 2006

-Well Point Dental
    -Report of the accessibility of the Husky Dental Network
    -Corrective Action Plans
    -Cities meeting the standard

State of Connecticut Department of Social Services
Quality Assessment and Performance Improvement (QAPI-438.240)
June 2006 P

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Section I
2006 Quality Improvement Program Description including 2006 Work Plans

Section II
2004 Regional Quality Report (2005 Annual Quality Report will be complete by August 2006)

Section III
Regional Quality Steering Committee Minutes (Copies of any committee meetings and attachments showing discussion or approval of quality projects)

Anthem- State of Connecticut Department of Social Services

Quality Assessment and Performance Improvement (QAPI)

Clinical Practice Guidelines (438.236)
2005-2006
P

Anthem Mercer Audit 2006
Medicaid Grievance/Appeals
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#2 Record reviews

#c. Appeals and grievance tracking logs or other monitoring/tracking process listing records by reason of denial and category or appeal or grievance for CY 2005

N. Minutes and or other documentation of actions addressing analysis of member complaints and grievances; 438.240, 438.402, 438.406, 438.416

V. Grievance files or aggregate data related to payment/non-payment for services; 438.406, 438.416

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2005-2006 Clinical Practice Guidelines

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Mercer Audit #438.236

- Regional Practice Guideline Development Policy
- Clinical Practice Guidelines
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Asthma
  - Cardiovascular Disease (CVD)
  - Depression
  - Diabetes
  - Prenatal and Perinatal Care
  - Prevention/Immunization Schedule
  - Substance Use Disorder
  - Adult Weight Management
  - Pediatric Weight Management
- Clinical Practice Guideline Review Schedule
- Physician Guideline Committee Review
- Regional Quality Steering Committee (RQSC) Approval
- Distribution
- Online Access at Anthem.com

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Q- CM/DM program description (if separate from above descriptions); 438.208

R- QM minutes indicating areas discussing issue, quality projects, integration of vendors
-LogistiCare
-OptiCare
-Value Options
-DBP

S- Provide copies of P&Ps that demonstrate that the MCO coordinates the services furnished to the member with the services the member receives from any other MCO, Behavioral Health Care Organization (BHCO), or Prepaid Inpatient Health Plan (PIHP); 428.236, 438.240

T- Annual utilization statistical report for CY 2005, including, but not limited to, case mix analysis, hospitalization, skilled nursing facility F), home health, and emergency/urgent care utilization statistics; 428.114, 438.240

U- Annual report of statistics for any call center operations (member services, UM) including monthly call volume, average speed to and abandonment rate; 438.240

V- See separate binder: Medicaid Grievance/Appeals

W- 2005 Education programs for customer service staff

X- Progress to determine eligibility for HUSKY Plus programs; 438.100

Y- HUSKY B member referrals to HUSKY Plus: include P&Ps and tracking information; 438.210, 438.208

Z- P&Ps and tracking demonstrating coordination of referral process for HUSKY Plus members; 438.208

BB- Documentation of coordination and reporting submitted to the State related to utilization of HUSKLY Plus; 438.207, 438.218

CC- P&Ps for billing and collecting HUSKY B premium; and 438.106

DD_P&PS and tracking of HUSKY B annual aggregate cost sharing limit, copayment, and repayment processes. 438.106, 438.108

Grievance Systems

A- See separate binder: Medicaid Grievance/ Appeals

B- WellPoint Dental Services Meeting Minutes
2005 Medicaid Quarterly Complaint Log

C- Medicaid Grievance /Appeals

D- Medicaid Grievance /Appeals

A- LogistiCare Policy and Procedure Manual
WellPoint Participating Dental Manual HUSKY A and B
OptiCare Member Rights
Dental Benefit Providers Member Rights
ValueOptions Members Rights and Responsibilities