December 20, 2006

External Quality Review
State of Connecticut

Anthem Blue Cross/Blue Shield
BlueCare Family Plan

MERCER
Government Human Services Consulting

Contents

1. Executive Summary 1

2. Introduction 4

3. Methodology 6

4. Compliance with Federal Medicaid Managed Care Regulations — Review of 2005 Corrective Action Plan 9

5. Compliance with Standards for Timeliness and Access to Services 40

6. Compliance with Specific Contract Requirements — HUSKY B, HUSKY Plus, and HUSKY B Co-Payment **Error! Bookmark not defined.**

7. Validation of Performance Improvement Projects ..... **Error! Bookmark not defined.**

8. Validation of Performance Measures ..... **Error! Bookmark not defined.**

9. Calculation of Performance Measures ..... **Error! Bookmark not defined.**

Appendices

Appendix A – Documentation Submitted for Review ..... **Error! Bookmark not defined.**

Appendix B – Agenda for On-Site Review Session ..... **Error! Bookmark not defined.**

Appendix C – MCO Corrective Action Plans ..... **Error! Bookmark not defined.**

1

Executive Summary

The State of Connecticut (State), Department of Social Services (DSS), has contracted with Mercer Government Human Services Consulting (Mercer) to be the State's External Quality Review Organization (EQRO). As required in 42CFR Part 438, Subpart E, Mercer completed an External Quality Review (EQR) of the managed care organization (MCO), Anthem BlueCare Family Plan (BCFP) in their offices in North Haven, Connecticut on August 15, 2006. BCFP is managed as part of the Anthem East Northeast Region (Connecticut, Maine, and New Hampshire). Annual EQRs are done in a three-year cycle; 2006 is the third year in the current cycle. During the first year, a comprehensive EQR was done, MCO compliance with all regulations related to the Balanced Budget Act of 1997 (BBA) was assessed. In 2007, the first year of a new three-year cycle, the EQR will once again be comprehensive.

The content of this EQR included:

- implementation by BCFP of its corrective action plan (CAP) related to recommendations from the EQR of 2005;
- compliance of BCFP with Federal Medicaid Managed Care regulations and State standards relating to quality, timeliness and access to services;
- performance improvement projects (PIPs) validation;
- performance measure (PM) validation;
- PM calculation; and
- at the request of DSS, BCFP compliance with Healthcare For Uninsured Kids and Youth (HUSKY) B contractual requirements.

The following include the strengths of BCFP identified during the EQR, as well as recommendation for improvement in areas of weakness. Detailed information about each area can be found in the body of this report.

Strengths

Strengths of BCFP are:

- It is a part of a national health care company that has a strong national infrastructure focused on managing health care delivery systems and Medicaid populations. It provides national support for its organizational policies, quality improvement (QI) program, network management processes and practices, 24-hour nurse advice line, and information systems data management.
- The local management team has tenured professionals leading administrative/operational practices.
- Processes for referral and coordination of members to HUSKY Plus were well-documented in policies, flowcharts, and in tracking materials.
- The Credentialing and Recredentialing processes are well-organized, timely, and complete.
- The PIPs are well-written overall, it is easy to track the progression of results over time and data methodology for PIPs is basically sound.

Recommendations

1. Use populations specific to provider services while conducting GeoAccess studies for primary care providers (PCPs) and specialty providers, to better identify true network adequacy ratios and mileage accessibility (children for pediatricians, women for OB/GYNs, etc.).
2. Review methodology differences between BlueCare Family Plan's dental 'secret shopper' calls and those done for HUSKY as findings conflict with each other.
3. Reports of survey activities should include follow-up information about health plan activities initiated to resolve outstanding issues.
4. Continue recruiting efforts to expand dental network.
5. Conduct follow-up on a statistically significant sample of providers who do not return the Calendar Access Requirements Survey to determine if providers are compliant with accessibility and availability standards.
6. Increase efforts to ensure that members receive preventive dental screenings and necessary dental services in all age groups by targeting efforts to non-compliant members.

7. Prior to conducting a member or provider survey, the MCO should submit a copy of the survey tool and the proposed methodology/protocol to DSS for review and approval.
8. Make modifications to BCFP's written provider standards to match DSS standards or keep more stringent standards and monitor according to the chosen standards.
9. Develop a network adequacy plan and evaluate it annually.
10. Continue to recruit for and to monitor the network adequacy of high volume physician specialty fields, particularly orthopedists and dermatologists.
11. Address case management (CM) documentation standards and audit them on a regular (monthly) basis through a defined peer review process.
12. Provide additional information in notices of action (NOA) to members explaining the reasons for denials in layperson language at the seventh grade reading level.
13. Include the use of benchmarks in all PIP studies to help guide and reinforce choice of goal; citing limitations if measurement criteria is different.
14. Expand and make accurate the PIP documentation.
15. Conduct an analysis of non-compliant members to determine barriers to the receipt of the recommended services and identify specific interventions to improve results.

2

Introduction

Federal regulations require that each state, that contracts with managed care organizations (MCOs) to deliver care to its Medicaid members, have an independent External Quality Review Organization (EQRO) validate performance improvement projects (PIPs) and performance measures (PMs) done by the MCOs. An External Quality Review (EQR) is also required. The State of Connecticut (State), Department of Social Services (DSS) requested that Mercer Government Human Services Consulting (Mercer) complete an EQR of the MCOs who deliver services to enrollees of the State's Medicaid Healthcare For Uninsured Kids and Youth (HUSKY) A program. Compliance with the HUSKY B contractual requirements was also included in the EQR.

Mercer requested certain documentation from each of the MCOs, which was reviewed prior to an on-site component of the Review. A list of the specific documents can be found in Appendix A of this report. The EQRO team interviewed Anthem BlueCare Family Plan (BCFP) staff in the organization's North Haven, Connecticut offices on August 15, 2006. Mercer used this process to better understand BCFP's operations and how they contributed to compliance with federal regulations.

The information obtained from the documentation and interviews was not independently verified or audited by Mercer, other than as is described in this report.

BCFP has approximately 128,000 members enrolled in the combined HUSKY A (Medicaid – 114,210) and HUSKY B (13,700) products.

BCFP subcontracts administrative and provider network service responsibilities with three entities - OptiCare for vision services, LogistiCare for transportation to non-emergency medical services, and Wellpoint Dental Services (as of November 1, 2005).

3

Methodology

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties, including clinical, analytical, coding, and information systems personnel, with talents that met the requirements of the EQR process.

The methodology used by Mercer during this review process was organized into five critical phases presented in the following diagram.

Request for Information

Mercer used the MCO Request for Information, designed by Mercer and modified to meet the needs of DSS to acquire information specific for all areas of the review. The specified information, such as policies and procedures (P&Ps), enrollee documents, and copies of program descriptions/evaluations were sent to Mercer prior to the on-site review. From the information received, Mercer identified records/files to be pulled for the on-site review relating to compliance, case management (CM), provider credentialing, and enrollee denials/appeals documentation.

Desk Review

Mercer reviewed all documents submitted by BCFP over a series of weeks. For the compliance area, Mercer developed and utilized a comprehensive EQR Compliance Review tool, which was adapted from the Centers for Medicare & Medicaid Services (CMS) protocols to assess compliance. The tool was tailored to meet the specific reporting requirements and to address the key issues and priorities of DSS. The tool assisted the reviewers in grouping documents according to processes related to the main areas of the third year review. The focus of the desk review was to:

- assess the extent to which BCFP had implemented its corrective actions related to recommendations from the previous year's EQR;
- identify general compliance with both the Balanced Budget Act of 1997 (BBA) and State-contractual rules and regulations for timeliness of, and access to, covered services; and
- identify compliance with State contractual requirements for the HUSKY B and the HUSKY Plus populations, CM procedures and documentation, and the adequacy of the specialty provider network.

The information gleaned from the desk review assisted Mercer in focusing on-site observations and interviews in areas where additional information was needed. A listing of all material reviewed for the compliance review can be found in Appendix A.

On-Site Review

The compliance and performance improvement on-site review took place on August 15, 2006 (see agenda in Appendix B for a complete listing of the interview groupings and sequencing.). The on-site review began with a combined introductory session with all appropriate BCFP staff. The reviewers conducted focused interviews with staff and completed CM, credentialing, and grievance and appeals file reviews. The interviews followed the major areas of required review — implementation of corrective actions, the quality and timeliness of, and access to, covered services as required by the State contract; and compliance with requirements for the HUSKY B and HUSKY Plus populations.

In following this sequence, Mercer complied with CMS regulations to conduct the EQR in a logical fashion that assisted in assessing BCFP's overall performance and its compliance with Federal and State rules and regulations. Many of the interview groups were multidisciplinary and reflected the flow of processes conducted by various departments in delivering information, education, and health care services to its Medicaid members.

At the end of the review phases, a comprehensive analysis was conducted of the information obtained from all activities. The results of this analysis make up this report and are written in a format consistent with federal protocols to easily identify compliance with Balanced Budget Act of 1997 (BBA) standards, as written in the *Federal Register*, June 14, 2002.

To summarize all the areas of review, Mercer followed CMS' protocol for monitoring Medicaid MCOs and used the required seven activities:

1. planning for compliance monitoring activities;
2. obtaining background information from the State Medicaid Agency;
3. documenting the review;
4. conducting interviews;
5. collecting any other accessory information;
6. analyzing and compiling findings; and
7. producing a report, which contains the final analysis and findings of the review.

4

Compliance with Federal Medicaid Managed Care Regulations — Review of 2005 Corrective Action Plan

Enrollee Rights and Protection

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Enrollee Rights and Protection The member will be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation) The enrollee's right to request that the medical record be amended or corrected. The enrollee who exercises their rights will not adversely affect the way the MCO and its providers treat the enrollee.	The intent of Enrollee Rights and Protections is to ensure that enrollee providers, vendors and staff are fully informed regarding Enrollee rights. BCFP should follow through with the development and distribution of a member bulletin updating Enrollee Rights information.	Vendors have produced new vendor policies on "Member Rights." LogistiCare, Dental Benefit Providers, Inc. (DBP) and OptiCare attached. Wellpoint Dental's will be forthcoming in 2006. Documents sent with CAP: ▪ LogistiCare Policy & Procedure, Member Rights; ▪ OptiCare Policy, Member Rights; and	Met Met Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
		▪ Dental Benefit Provider Policy, Member Rights and Responsibilities. Member Update with enrollee rights was completed and mailed in October 2005 (copy attached of BCFP Member Notice, 10/05 re: Member Bill of Rights & Responsibilities) January 27, 2006: Wellpoint Dental's Member Rights and Responsibilities Policy (copy attached of Wellpoint Dental Policy, Member Rights.)	

Comments:

Administrative, provider, and vendor policies have been updated to include all the required enrollee rights, including, but not limited to, the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation; the right to request that the medical record be amended or corrected; and the right to exercise rights without any adverse effects. A Wellpoint Dental Memo (Spanish and English version) announcing dental services and members rights was distributed to members in October 2005, and it was also completed. *Member Handbook*s (HUSKY A and B) (revised 8/15/2006) draft copies included the right to be free from restraints, or seclusion used as a means of coercion, discipline, convenience, or retaliation, the right to exercise rights without any adverse effect on treatment, and the right to request that the medical record be amended or corrected.

Recommendations:

None

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings
Enrollee Rights and Protection Information regarding what constitutes post-stabilization services.	BCFP should include the definition of post-stabilization services in the *Member Handbook*, as specified in the work plan, and include the definition in the member bulletin created and distributed to members informing them of additional rights. This bulletin was intended to provide information to members while awaiting approval of the updated *Member Handbook*, which is in approval process.	Definition of post-stabilization services ("Post-Stabilization care services are usually needed to evaluate and/or stabilize a patient during an emergent medical situation. Upon receiving emergency treatment your provider may require additional services in order to further assess your medical condition") will be included in the revised Member Handbook (on page 5 next to the Urgent Care & Emergency sections). *Member Handbook* is slated for completion in second quarter 2006.	Met

Comments:

Post-stabilization information has been inserted into the revised *Member Handbooks* (HUSKY A&B). However, on page 5 of the handbook submitted for review dated June 2006, immediately after the post-stabilization paragraph, in the same section, was a statement: "Note: When you travel outside Connecticut, you are covered only for emergencies." This line may be confusing to members, as it seems to contradict the previous post-stabilization paragraph. Post-stabilization services are required to be covered regardless of location or occurrence. BCFP removed the confusing paragraph and the handbooks are now compliant and ready for Fall publication.

Recommendations:

None

Timeliness and Access to Services

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Standards for Timeliness and Access to Services The MCO shall serve members statewide. The MCO shall ensure that its provider network includes access for each member to PCPs, OB/GYN providers, and behavioral health (BH) providers at a distance of no more than: ▪ 15 miles for PCPs and OB/GYNs; and ▪ 20 miles for general dentists as measured by the Public Utility Commission.	A plan to track and monitor overall primary care provider compliance with access requirements should be developed. The MCO should begin to produce reports for dental and BH services, which reflect distance requirements. This will support monitoring of compliance standards.	As of January 1, 2006, Behavioral Health & Substance Abuse Services are assigned to the State's DSS Behavioral Health Partnership. Wellpoint Dental has agreed to produce a quarterly network access report. Their first network access report is attached. Documents sent with CAP: ▪ HUSKY Dental Network – Accessibility Overview within County; ▪ 2004 PCPs – Medicaid Members 12/2004 – Cities meeting the access standard; ▪ 2005 PCPs – Medicaid Members 12/2005 – Cities meeting the access standard; ▪ 2004 Medicaid Dentists – Medicaid Members 12/2004 – Cities meeting the access standard; and ▪ 2005 Medicaid Dentists – Medicaid Members 12/2005 – Cities meeting the access standard.	Partially Met Met Partially Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations

Comments:

Dental Access: BCFP does have a network monitoring process in place for PCPs and Dentists. During 2005, Dental Standards were not met under BCFP's contract with DBP. BCFP required CAPs to be written by DBP and even applied monetary sanctions. As of October 31, 2005, the contract with DBP was terminated and on November 1, 2005, BCFP changed their dental contract to Wellpoint. By the end of 2005, BCFP using GeoAccess measurements determined that the dental network was sufficient to handle membership in all counties with the exception of one city, Lakeville, in Litchfield county. Using ratio standards of members to dentists, they determined that their network was adequate except for two counties, Fairfield and Litchfield counties. On May 1, 2006, BCFP received a notice from DSS stating that they had three counties, Hartford, Litchfield, and Tolland, out of ratio compliance secondary to BCFP counting dental hygienists incorrectly. The DSS Contract states: "For purpose of enrollment capacity a dental hygienist meeting the criteria of Connecticut General Statutes Section 20-1261, with two (2) years of experience, working in an institution (other than hospital), a community health center, a group home, a preschool operated by a local board of education or head start program, or a school setting shall be counted as fifty (50) percent of a general dentist." As a consequence, DSS froze enrollment in Hartford, Litchfield, and Tolland counties. DSS identified that BCFP was counting dental hygienists practicing in private dental offices and therefore, these practitioners could not be counted as part of the network for capacity purposes. BCFP states that their Dental Network Access Standards are now tabulated using accurate provider counts. BCFP is continuing to actively recruit dental providers across the State. TAs of May 15, 2006, they have a panel of 405 dentists and dental hygienists) at 738 sites (ratio of approximately 3 dentists to 1 hygienist). The three deficient counties need a total of11.5 dental providers to meet ratio standards (Hartford 2.5, Litchfield 7.0, and Tolland 2.0). As of 08/01/2006, DSS re-opened all Counties in Connecticut to BCFP member enrollment.

BlueCare Family Plan dental access is monitored by random 'secret shopper' telephone calls to at least 20 groups per month. Providers must meet at least 85 percent for compliance. Tracking sheets demonstrate 100 percent compliance. However, there is no indication of any calls not being answered, or wrong numbers, or anyone being too busy to talk, or not having timely appointments – all issues, which routinely occur during these type of phone calls. A number of providers had closed panels, but were compliant for appointment timing for current members. In contrast, in 2005, BCFP also conducted HUSKY 'secret shopper' phone calls to dental provider offices. The results of these calls demonstrated that new members may have difficulty in finding appointments in a timely manner secondary to unavailability of timely appointments. The reports did not indicate any follow-up from Provider Relations to resolve issues. Additionally, BCFP does monitor General Dentistry/Specialist Not Available Inquiries from members. Through October, 2005, they had received 338 calls from members needing assistance in finding an available specialist or general dentist.

Primary Care Providers: A provider network analysis computing PCP to member ratios is conducted monthly for PCPs and OB/GYNs. GeoAccess reports are run annually. PCP standards were not being met in four counties in 2005. As of first quarter, 2006, BCFP met access standards for PCPs for 99.02 percent of their members. Access reports for 2005 demonstrate that OB/GYN Medicaid provider ratios were not calculated correctly, as BCFP used an erroneous standard of 1 provider within 20 miles, rather than 1 in 15 miles. However, they also used the entire population to run the report, rather than older adolescents and adult females.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Recommendations: Review methodology differences between BlueCare Family Plan 'secret shopper' calls and those done for HUSKY as findings conflict with each other and with the number of phone calls from members needing assistance in finding available dentists/specialists. Prior to conducting provider or member surveys, consider submitting methodology to DSS for review and approval. Reports of survey activities should include follow-up information about health plan activities initiated to resolve outstanding issues. Continue recruiting efforts to expand dental network. Run access standards for OB/GYNs using 1 provider within 15 miles and limit the population to females age 14 and over. Use populations specific to provider services while conducting GeoAccess studies for PCPs and specialty providers, to better identify true network adequacy ratios and mileage accessibility (children for pediatricians, women for OB/GYNs, etc.).			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Standards for Timeliness and Access to Services The MCO shall ensure that the PCPs in its network adhere to the following PCP scheduling practices: ▪ emergency cases shall be seen immediately or referred to an emergency facility; ▪ urgent cases shall be seen within 48 hours of PCP notification; ▪ routine cases shall be seen within 10 days of PCP notification; ▪ well care visits shall be scheduled within 6 weeks of PCP notification; ▪ Early Periodic Screening Diagnosis and Treatment (EPSDT) comprehensive exams shall be scheduled in accordance with the Departments Health Track periodicity and immunization schedules; ▪ new members shall receive an initial PCP appointment in a timely manner (for those members who do not access goods and services within the first 6 months of enrollment, the MCO shall identify and remedy any access problems; and ▪ waiting times at PCP's are kept at a minimum.	Develop a plan to track and monitor overall PCP compliance with access requirements. This access plan would allow the MCO to track an overall compliance rate to access requirements.	Documents sent with CAP:* ▪ BCFP Policy to Monitor Provider Access Requirements; ▪ BCFP Policy to Monitor Provider Calendar Access Requirements; ▪ BCFP Provider Access Goals-2005 – PCP; and ▪ BCFP Provider Access Goals-2005 – Specialist. * *All the other attachments, sited in the Provider Access Goals and Calendar Access Requirements, were submitted with the original documentation under the Quality Assessment and Performance Improvement (QAPI) section (e.g., newly credentialed report, non-par request form).*	All Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations

Comments:

BCFP's availability/accessibility written standards are compliant. For monitoring provider accessibility and availability, BCFP has multiple venues for identifying compliance with accessibility and availability. BCFP developed a process whereby Provider Network staff on a monthly basis monitors participating PCPs and Specialists via a Calendar Access Requirements Survey form, which is provided to PCPs or Specialists for completion during an in-office visit or via fax. So far, in 2006, 512 access surveys have been sent to providers showing only two providers who did not meet standards. However, only 27.3 percent of the providers receiving the survey returned it. No real follow-up has been done to identify accessibility/availability standards for those providers not returning the surveys. However, HealthReach, Member Services, and Quality of Service staff refer cases to Provider Network when they identify a provider who is not adhering to above requirements or when a member complaint is received. Provider Network has an education process that is provided to providers not adhering to standards.

Members have been informed of access standards in the *Member Handbook*.

Recommendations:

Conduct follow-up on a statistically significant sample of providers who did not return the Calendar Access Requirements Survey to determine if providers are compliant with accessibility and availability standards.

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Standards for Timeliness and Access to Services The MCO shall contract with a sufficient number of dentists throughout the state to ensure access to oral health.	BCFP should continue the following activities for dental: develop and implement recruitment plans related to increasing dental staff in the network.	Wellpoint Dental Services is the new subcontractor for all HUSKY dental services effective 11/1/05. Wellpoint Dental will begin a 2006 Dental Enhancement Plan in January 2006. Dr. Gong, the VP of Provider Relations, has many new, exciting ideas for enhancement to services. On October 1, 2005, an Escalated Matters Unit is up and running. The unit that is located in California is open from 5:00 AM – 2:00 PM to reflect EST. The Unit handles all concerns from BCFP members and providers. Wellpoint Dental has two recruiters in the State every week since August 2005. They have a CAP in place to meet their recruitment goals. **01/27/06 Update:** The State's DSS has agreed to allow Wellpoint Dental until 03/31/2006 to bring their provider network within DSS contractual standards.	Partially Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
		The report below is broken down by the State's counties. It expresses the State's DSS contractual standards, which states the network standards for dental providers: 1 dental provider, including general and pediatric dentists counted at 100 percent, and dental hygienists counted at 50 percent, (486 Members per provider). Copy of National Geographic Access Summary, Date: December 2005 was sent with the CAP for review. A CAP is also in place. This CAP has been shared with the State's DSS. Please review the present Wellpoint Dental Corrective Action and the recruitment objectives. Copies of the Wellpoint Dental Services Corrective Action Plan, Provider Network Adequacy, and BCFP Dental Network Recruitment Summary Report – Projections as of 1-25-06 were sent with the CAP for review.	

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: BCFP has made significant strides in late 2005 and early 2006, to correct general dental access standard deficiencies from 2005. Wellpoint Dental Services became the subcontractor for all HUSKY dental services effective 11/1/05. Documents provided during the review included CAPs and evaluations of remedial activities to enhance the dental network. Recruitment strategies have significantly expanded the dental network across the State for both general dentistry and orthodontia. During the review, all monitoring documents submitted appeared to be related to general dentistry and not to orthodontia.			
Recommendations: Conduct dental network adequacy monitoring for orthodontia services.			

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Compliance with Standards for Timeliness and Access to Services To ensure that access standards are met with respect to dental screenings and appt availability. The MCO shall ensure that the scheduling of a routine dental visit is within six weeks. Provided for sufficient access to dental services for different ages: ▪ The MCO shall ensure that no less than 80 percent of continuously enrolled members shall receive 1 screening and dental cleaning per 12-month period.	Continue to work in partnership with DSS and WDS to identify opportunities to improve access; continue performance improvement initiatives in place to improve screening rates and examine options to expand interventions; review goals by age group to assure ongoing improvement is identified; and continue the expedited unit to assist members who have difficulty to access a dental provider.	Wellpoint Dental is performing "secret shopper calls" on a monthly basis. Wellpoint Dental will report their first quarter 2006 results to the BCFP on a quarterly basis. The first quarterly 2006 report is due on May 15, 2006. Dr. Donna Balaski, from CT DSS, has given Wellpoint Dental until second quarter 2006 to enact their Quality Initiatives. The BCFP and Wellpoint Dental Services 2006 Dental Access Enhancement Work Plan template is attached. Wellpoint Dental is forming a study on Early Childhood Caries Prevention. The template for this study will be sent to the BCFP by March 31, 2006.	Partially Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations

Comments:

BCFP monitors access to dental screenings and appointment availability; however, EPSDT statistics in 2005 indicated that only 21 percent to 35 percent of children ages 2 to 20 received dental services. This is significantly below the required 80 percent. However, BCFP conducted a variety of interventions to increase utilization of dental services including:

- sending out EPSDT reminder postcards on members' birthdays to set up dental appointments;
- including the importance of good dental hygiene as a subject on the Welcome Call script for new members;
- conducting dental outreach at a Special Olympics event; and
- forming an Escalated Unit call center to interact with members unable to find a dentist.

Recommendations:

Increase efforts to ensure that members receive preventive dental screenings and necessary dental services to all age groups by targeting efforts to non-compliant members.

Prior to conducting a member or provider survey, the MCO should submit a copy of the survey tool and the proposed methodology/protocol to DSS for review and approval.

Performance Improvement Projects

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 1. Review the selected study topics			
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	**PM** Included in the PIP documentation was a description of the prevalence and importance of breast cancer to women at the national and state level; however specific demographics, prevalence rates and impact to BCFP members was not addressed.	The program is offered to 4,505 women over 40 years of age enrolled in the BCFP. Demographically, this represents 4 percent of the BCFP population. Also, according to a recent cost/frequency report, breast cancer ranked in the top 30 percent of ETG's with a 12-month cost of $1 million. Demographic and cost/frequency information will be added to the "Activity selection and methodology" section of the PIP.	Met
Comments: Specific demographics, prevalence rates, and impact to BCFP members were addressed in latest study documentation.			
Recommendations: None			

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 4. Review Identified Study Population			
4.1 Did the MCO clearly define all Medicaid members to whom the study question and indicators are relevant.	**PM** The study defined the participants, however the written study documentation was not consisted with the attached DSS specifications.	As DSS modified the measurement specifications at the end of May 2005 and documentation needed to be submitted by June 15, 2005 there was insufficient time to assess the full impact and address any data limitations. Moving forward the Plan will work with DSS to address specifications, allowable codes and any limitations.	Met
Comments: The PIP included BCFP female members age 41 - 69, consistent with DSS age specification for study inclusion. The study, appropriately, did not exclude members with special health care needs (SHCNs).			
Recommendations: None			

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 4. Review Identified Study Population			
4.2 If the MCO studied the entire population, did its data collection approach capture all members to whom the study applied.	**PM** The study collection approach with identified codes would not have accurately identified all members of the denominator, due to inconsistencies in codes impacting the denominator. See below.	Same as above	Met
Comments: The breast cancer screening study description clearly defined the members to be included in the study. Members included met the reporting criteria set forth by DSS.			
Recommendations: None			

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 4. Review Identified Study Population			
4.3 Are study specifications compliant with DSS	**PM** Denominator: age range and timeframe consistent Exclusions: unilateral codes, CPT codes listed as applied. ICD-9 CM codes were not listed. Study documentation indicated that modifiers were not included as the BCFP system did not accept greater than 2 digit modifiers. Bilateral codes: the study indicated that codes for bilateral mastectomy were not used. Numerator: CPT codes, V codes and UB 92 codes were consistent Breast Cancer ICD 9 CM screening codes 87.36 and 87.37 were not included; by not including these codes the numerator is impacted.	Same as above. Will state in PIP "baseline methodology" section that the Plan's system does not accept ICD-9 codes.	Met
Comments: Supporting documentation regarding data collection methodology showed that DSS specifications were used for collecting data for all members in the study.			
Recommendations: None			

Improving the Breast Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 8 Review Data Analysis and Interpretation of Study Results			
8.3 Did the analysis identify initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity?	**PM** Statistical significance was included for the increase in trend from the baseline of 29.7 percent to Re-measurement #3 resulting in 34.2 percent. Factors influencing data comparability were included. Comparability between cycle 3 and prior year's results were impacted by a change in specifications. It was noted that there were no limitations to the study data impacting results. However, information system limitation did exist related to system inability to include all modifiers. While impact of including modifiers was unknown, and perhaps the impact was small, regardless of the size of the impact, any limitation should be identified.	Will state in PIP "baseline methodology" section that the Plan's system does not accept ICD-9 codes	Met
Comments: The analysis showed repeated measurements for five measurement periods, 2001 through 2005. Statistical significance was addressed in the analysis of each re-measurement period. Threats to reliability and validity were addressed as limitations and methodological changed.			
Recommendations: None			

Improving the Cervical Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services?	**PM** The Cervical Cancer Screening program began in 1996 and became a PIP in 2001. The literature review included in the study indicated prevalence rates of cervical cancer for 2001 and that 100 new cases would be diagnosed in women in the state. While a regional approach was mentioned, the specific analysis of the prevalence or impact to female members of BCFP was not addressed.	The program is offered to 21,635 women aged 18 and over enrolled in the BCFP. Demographically, this represents more than 17 percent of the BCFP population. Also, according to a recent cost/frequency report, cancers of the female genital track ranked in the top 50 percent of ETG's with a 12-month cost of $570,000. Demographic and cost/frequency information will be added to the "Activity selection and methodology" section of the PIP.	Met
Comments: The cervical cancer screening topic was selected based on the importance of screening to prevent invasive cervical cancer. Prevalence was cited for the US, the State, and BCFP to support rationale. PIP addressed the State's DSS PIP requirements.			
Recommendations: None			

Improving the Cervical Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 4. Review Identified Study Population			
4.1 Did the MCO clearly define all Medicaid members to whom the study question and indicators are relevant	**PM** While the study documentation indicated the DSS specs were applied, in reviewing the documentation submitted, variation occurred in defining identified codes for the study population.	Numerator – the Plan's system does not capture LOINC or ICD-9 codes, however, crosswalk codes will be researched if available. Moving forward, the Plan will work with DSS to allow the P3001 code that HEDIS accepts.	Met
Comments: The Study description clearly defined the members to be included in the Study. The age range was specified as 18 – 64 and broken into age categories. Members included in the study met the reporting criteria set forth by DSS with the exception that there was a slight inconsistency in two codes – one required diagnosis code was missing and one procedure code was repeated in the SAS program. More information about this can be read in Chapter 8. The P3001 code is an acceptable code for use.			
Recommendations: None			

Improving the Cervical Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 4. Review Identified Study Population			
4.2 If the MCO studied the entire population, did its data collection approach capture all members to whom the study applied	**PM** The study collection approach with identified codes would not have accurately identified all members of the denominator, due to inconsistencies in codes impacting the denominator. See below.	As above	Met
Comments: The Study description clearly defined the members to be included in the Study. Members included in the study met the reporting criteria set forth by DSS.			
Recommendations: None			

Improving the Cervical Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 4. Review Identified Study Population			
4.3 Are study specifications compliant with DSS	**PM** **Denominator:** the denominator should have been broken into two age ranges, 18 – 20 and 21 – 64 **Exclusions:** ICD-9 CM codes 64.4-68.8 not applied. **Gap:** consistent. **Numerator:** screening codes, CPT codes, V codes and UB 92 codes were consistent. LOINC, ICD-9 CM code 91.46 were not identified as included. P3001 was identified as included; however, this was not in DSS specifications. Numerator and denominator definitions in the study documentation were labeled incorrectly.	The Cervical Cancer Screening PIP has been in place since 2001 and the Plan's data results have been presented in aggregate format since that time. Moving forward, the Plan will present the data broken into the two specified age ranges. Will state in PIP "baseline methodology" section that the Plan's system does not accept LOINC or ICD-9 codes. The typo in the body of the PIP mislabeling the numerator and denominator has been corrected.	Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: The Study description clearly defined the members to be included in the Study. The age range was specified as 18 – 64 and broken into age categories. The numerator and denominator definitions were labeled correctly. The P3001 code is acceptable to both the Health Plan Employer Data and Information Set (HEDIS) and DSS.			
Recommendations: None			

Improving the Cervical Cancer Screening Rates

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Step 8. Review Data Analysis and Interpretation of Study Results			
8.2 Did the MCO present numerical PIP results and findings accurately and clearly?	**PM** Study results were indicated in a clear and numeric format, however the results were not presented in age ranges but in composite form.	The Cervical Cancer Screening PIP has been in place since 2001 and the Plan's data results have been presented in aggregate format since that time. Moving forward, the Plan will present the data broken into the two specified age ranges.	Met
Comments: The Study description clearly defined the members to be included in the Study. The age range was specified as 18 – 64 and broken into age categories.			
Recommendations: None			

Appropriate Use of Asthma Medications

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Review Identified Study Population			
4.1 Did the MCO clearly define all Medicaid members to whom the study question and indicators are relevant	**PM** While the study documentation indicated the DSS specs were applied, in reviewing the documentation submitted, variation occurred in defining identified codes for the study population.	In the baseline methodology section of the PIP document, BCFP will add the 2 CPT and 2 UB92 codes that were included in the data pull but were inadvertently omitted from the PIP language. In the future, will assure all codes used are noted in this section.	Met
Comments: The Study description clearly defined the members to be included in the Study. The age range was specified as 5 – 56 and broken into age categories as suggested in the previous year's audit. Members included in the study met the reporting criteria set forth by HEDIS and DSS.			
Recommendations: None			

Appropriate Use of Asthma Medications

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
4.2 If the MCO studied the entire population, did its data collection approach capture all members to whom the study applied	**PM** For the study participants included the whole population as described by the specifications.	Need clarification as to why this is noted as partially met and any desired next steps.	Met
Comments: The Study description clearly defined the members to be included in the Study. Members included in the study met the reporting criteria set forth by HEDIS and DSS.			
Recommendations: None			

Appropriate Use of Asthma Medications

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
4.3 Are study specifications compliant with DSS specifications?	**PM** **Denominator:** inpatient CPT codes 99356 and 99357 and UB 92 codes 72, and 80X were not identified in the study populations. **Exclusions:** consistent. **Gap:** consistent. **Numerator:** NDC codes from National Committee on Quality Assurance (NCQA) website.	In the baseline methodology section of the PIP document, BCFP will add the 2 CPT and 2 UB92 codes that were inadvertently omitted. In the future, BCFP will assure all codes used are noted in this section.	Met
Comments: Study specifications are compliant with DSS.			
Recommendations: None			

Appropriate Use of Asthma Medications

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
8.2 Did the MCO present numerical PIP results and findings accurately and clearly?	**PM** Study results were to be broken into three age ranges and a composite category. Composite study results were indicated in a clear and numeric format with results as 61.21 percent.	BCFP will include the age breakdown within the PIP document.	Met
Comments: Findings were reported in the PIP Documentation, providing easy reference to results for each measurement period and progress with improvement between the baseline reporting period and first re-measurement period. Age breakdown was included in the PIP document.			
Recommendations: None			

Validation of Performance Measures

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Objectives: ▪ Validate the accuracy of Medicaid PMs reported by BCFP − Asthma Medications − EPSDT − Access to Prenatal Care − Adequacy of Prenatal Care ▪ Determine the extent to which Medicaid specific PMs calculated by an MCO followed specifications established by DSS for the calculation of PMs	BCFP was found to be "Fully Compliant" in each PM.		Partially Met
Comments: BCFP was identified as being fully compliant for three of the performance measures – Asthma Medications, EPSDT, and Cervical Cancer Screening. The fourth measure, adequacy of prenatal care could not be validated as the exact specifications utilized to calculate the measure was not clearly disclosed in the documentation provided for the review. See Chapter 8 for additional information.			
Recommendations: None			

Calculation of Performance Measures

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Objectives: ▪ To calculate Medicaid PMs for BCFP in accordance with specifications prescribed by DSS: − Newborn Intensive Care Unit (NICU) Admits/100 Births − Emergency Department (ED) visits/1000 members − Readmission Rates − Diabetic Retinal Exams − Breast Cancer Screenings/Mammograms − ED Visits by Asthmatics ▪ To provide information to DSS on the extend to which BCFP Information Systems provided accurate and complete information necessary for the calculation of PMs	Last year, Mercer recommended that BCFP re-evaluate their data collection/claims effort to determine if they are achieving a complete accounting of diabetic retinal exams. Additional recommendations were that BCFP's diabetic patients should be tracked by their PCP. Quarterly reports should be issued to PCPs listing diabetics who had not received their diabetic retinal exam. Although BCFP has increased their rate, they are still substantially lower than national standards. Mercer recommends that BCFP continue their efforts in this area. Re-evaluation of data collection/claims efforts was recommended for breast screening for BCFP last year. In addition, root cause analysis and activities designed to increase the rates of mammography were suggested. BCFP has increased their breast screening rates, but it is recommended they continue their efforts in this area.	Anthem Blue Cross and Blue Shield will continue to remind members of the importance of a yearly dilated eye exam. Given that the BCFP dilated eye exam methodology differs from the Medicaid HEDIS methodology, the plan cannot be compared to the national benchmark. The plan will consider provider interventions. The Plan did a barrier analysis in 2005. The Plan will continue to implement member reminders.	Met

Regulation Found Partially or Non-Compliant During 2005 Review	Recommendations from 2005 Review	MCO Proposed Corrective Actions for 2006	2006 Findings of Compliance with 2005 Recommendations
Comments: BCFP's NICU rate has increased from 8.3 percent to 10 percent. However, it is significantly lower than rates from other Medicaid health plans in the State. The ED visit rate is comparable to the State average. Hospital readmission rates have slightly increased. Mercer calculated the diabetic retinal exams and the breast cancer screenings performance measures using HEDIS specifications. The breast cancer screening rate was 35.9 percent which was a slight increase above 2004, but it is significantly below the Medicaid national average of 54.1 percent. The methodology for calculating the diabetic retinal exam changed in HEDIS 2006, resulting in a substantial increase in the rates. This makes it difficult to compare the 2005 results to those of 2004. ED usage by asthmatic members has increased from the 2004 rate. See Chapter 9 for additional information.			
Recommendations: Conduct an analysis of non-compliant members to determine barriers for them in receiving the appropriate services. Identify specific interventions focused on the barrier analysis to improve the rates.			

5

Compliance with Standards for Timeliness and Access to Services

Standards for Timeliness and Access to Services	Analysis	2006 Findings
Coordination and provision of EPSDT screening services in accordance with the schedules for immunizations and periodicity of well-child services as established by the DEPARTMENT and federal regulations. Provide necessary coordination and CM services for children with special health care needs CSHCNs).	BCFP demonstrated the monitoring, coordination, and provision of EPSDT screening services in accordance with both DSS and federal regulations. Screening ratios and participant ratios are consistent with 2004 results. Statistics demonstrate that children in the below age 1 through age 9 are meeting the screening ratio requirements of 81 percent, but the screening ratios for the 10 and above age groups drop progressively from 73 percent to 39 percent for the 19 – 20 age groups. Participant ratios are approximately 62 percent for the first half of 2005 and 71 percent for	Met Met

Standards for Timeliness and Access to Services	Analysis	2006 Findings
	the second half. The percentages again are higher in the younger age groups and progressively drop off as the children age. The BCFP Health Reach program conducts follow-up with members and providers to ensure that children missing screening services are contacted and notified of the importance of receiving the health services. The providers receive a personal profile indicating how they are performing related to EPSDT screening requirements. Provider relations representatives work with providers who have low screening rates to assist them in improving their members' access to required services. A review of documents submitted for the EQR and of an on-site random CM files review demonstrated that CSHCNs do receive coordination and CM services. HUSKY B members were referred to HUSKY Plus and CM coordinated care between the health plan and HUSKY Plus services.	
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall provide all emergency services 24 hours each day, 7 days a week or arrange for the provision of said services 24 hours each day, 7 days a week through its provider network. The MCO shall cover and pay for emergency services without regard to prior authorization and regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO shall not limit the number of emergency visits.	Members are notified in the *Member Handbook* of their rights to emergency care and what the standards are for providers. The provider manual informs providers of the federal requirements for the provision of emergency services. Member complaints were monitored by BCFP and demonstrated no complaints about access to emergency care. A review of the denial logs determined that there were no denials related to payment of emergency services. Emergency services are not prior authorized and there is no limit placed on the number of emergency visits.	Met Met Met
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall serve Members statewide. The MCO shall ensure that its provider network includes access for each Member to PCPs, OB/GYN providers, and mental health providers at a distance of no more that 15 miles for PCPs and OB/GYNs and no more than 20 miles for general dentists and mental health providers as measured by the Public Utility Commission. The MCO shall ensure that its provider network has the capacity to deliver or arrange for all goods and services reimbursable under the Medicaid FFS program.	BCFP does monitor the adequacy of the provider network on a monthly and annual basis. The BCFP ratio of practitioner per 1,000 member standards are: ▪ PCPs 1.00; ▪ Internists 0.34; ▪ Family Practitioners 0.33; ▪ Pediatricians 0.33; ▪ OB/GYNs 0.25; and ▪ Other specialists 0.125. BCFP is meeting all of these standards. BCFP's Geographic Availability Standards as identified in their national policies are: ▪ PCPs – 2 within 8 miles; ▪ OB/GYNs – 2 within 8 miles; and ▪ other specialists – 1 within 15 miles.	Met

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
	The PCP and OB/GYN written standards are more strict than required by DSS. BCFP, however, monitors the standards according to DSS standards. This creates an inconsistency. If BCFP chooses to adopt more strict standards, then it should monitor the accessibility accordingly. Other statistical inconsistencies related to the GeoAccess monitoring have been previously discussed in Chapter 4, but none of these findings are serious enough to prevent a rating of being compliant as the DSS accessibility standards are being met by BCFP.	

Recommendations:

Make modifications to BCFP's written provider standards to match DSS standards or keep more stringent standards and monitor according to the chosen standards.

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall maintain a provider network capable of delivering or arranging for the delivery of all covered health goods and services to all Members. In addition, the MCO's provider network shall have the capacity to deliver or arrange for the delivery or all the goods and services reimbursable under this contract regardless of whether all of the goods and services are provided through direct provider contracts. The MCO shall submit a file of their most current provider network listing to the DEPARTMENT or its agent. The file shall be submitted at a minimum, once a month in the format specified by the DEPARTMENT. In establishing and maintaining its provider network, the MCO shall consider the following: 1. anticipated enrollment; 2. expected utilization of services, 3. taking into consideration the characteristics and health care needs of the specific Medicaid populations in the MCO; 4. the number and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services; the numbers of network providers who are not accepting new Medicaid patients; and 5. the geographic location of providers and Medicaid Members, considering distance, travel time, the means of transportation ordinarily used by Medicaid Members, and whether the location provides physical access for Members with disabilities.	BCFP has not developed an Annual Provider Network Adequacy Plan. They did lose membership of approximately 7,000 in July 2006 secondary to eligibility changes, which did have an impact on their provider network. However, BCFP does conduct a variety of tasks to assist in determining network adequacy including: ▪ producing quarterly provider capacity reports, ▪ monitoring out-of-network (OON) authorizations to determine service capacity issues, ▪ reviewing service utilization reports, ▪ monitoring EPSDT screens and services, ▪ receiving feedback from vendors, Health Reach, provider services, providers, and members, ▪ running provider ratio and GeoAccess reports for PCPs and selected specialty areas, and ▪ monitoring enrollment changes.	Met
Recommendations: Develop a Network Adequacy Plan and conduct an evaluation of it annually.		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall ensure that the PCPs in its network adhere to the following PCP scheduling practices: 1. Emergency cases shall be seen immediately or referred to an emergency facility; 2. Urgent cases shall be seen within 48 hours of PCP notification; 3. Routine cases shall be seen within 10 days of PCP notification; 4. Well-care visits shall be scheduled within six weeks of PCP notification; 5. EPSDT/Health Track comprehensive health screens and immunizations shall be scheduled in accordance with the Department's Health Track periodicity and immunization schedules; 6. New Members shall receive an initial PCP appointment in a timely manner; (for those Members who do not access goods and services within the first six months of enrollment, the MCO shall identify and remedy any access problems; and 7. Waiting times at PCPs are kept to a minimum.	BCFP monitors their network to ensure timeliness and access to services for their members including: ▪ notifying members via the *Member Handbook* of scheduling and emergency care standards, ▪ monitoring EPSDT reports, ▪ conducting 'Secret Shopper' phone calls to provider offices, ▪ conducting new member welcome calls to remind members of their benefits and how to utilize the health care delivery system appropriately, ▪ offering a 24 hour Nurse Call Line option for members to call for advice and discussion of any health concerns, ▪ monitoring member complaints; and ▪ monitoring of CAHPS results.	Met

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
	The 2005 CAHPS results for member satisfaction for routine care and non urgent appointments demonstrated that 93.9 percent of the responding members believed they were able to schedule an appointment as soon as they wanted and within less than 15 days. The members that believed they were able to receive urgent care as soon as they wanted was 72.6 percent. Members are informed of the 24-Hour Nurse Call Line service and the telephone number is listed in the *Member Handbook*. The Nurse Call Line is provided by Health Management Corporation and provides decision-support services. BCFP has appropriate written policies providing guidance for customer service representatives for when members call seeking emergency services.	
Recommendations: None		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall contract with a sufficient number and mix of specialists so that the Member population's anticipated specialty care needs can be substantially met within the MCO's network of providers. The MCO will also be required to have a system to refer Members to OON specialists if appropriate participating specialists are not available. The MCO shall make specialist referrals available to its Members when it is medically necessary and medically appropriate and shall assume all financial responsibility for any such referrals whether they be in-network or OON. The MCO shall ensure that the Member does not incur any costs for such referrals whether the referral is to an in-network or OON provider. The MCO must have policies and written procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals to specialty providers.	BCFP reported that members are asked to discuss their need for a specialist with their PCP. Primary Care Practitioners and select specialty providers, such as OB/GYNs, ENT, and Ophthalmology providers are being monitored for GeoAccess and they meet the average distance to 1 provider within 20 miles standard. Dermatology and Orthopedic specialists are also being monitored via GeoAccess. Each of these specialties have three counties in which the 1 provider within 20 mile standard is not being met. Practitioner to member ratios are monitored and the network did meet established ratios for all high volume specialties identified (cardiologists, orthopedists, general surgery, and OB/GYN) except for ophthalmology for 2005. Information about non-participating providers is given to members in the *Member Handbook*. BCFP does have a policy outlining monitoring and care coordination of new members seeing OON providers. Policies allowing continuing members to seek care from OON providers if care is not available within the network were	Met

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
	available. OON referral processing and management is discussed in the Medical Management Program Description 2006. BCFP does have billing policies that prevent billing of members for both in-network and OON services. Referrals to specialty providers are tracked in the information system.	
Recommendations: Continue to recruit for and to monitor the network adequacy of high volume physician specialty fields, particularly orthopedists and dermatologists.		

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall contract with a sufficient number of dentists throughout the state to assure access to oral health care. The MCO shall:	The analysis of the dental network has already been discussed in Chapter 4, pages 18 and 19.	
1. Maintain an adequate dental provider network throughout the state's eight counties including access to orthodontic services.		Partially Met
2. Implement a plan that includes a systematic approach for enhancing access to dental care through monitoring appointment availability, provision of training to providers around issues of cultural diversity and any other specialized programs.		Met
3. To ensure that access standards are met with respect to dental screens and appointment availability, the MCO shall ensure that the scheduling of a routine dental visit is within 6 weeks.		Partially Met
4. Provide for sufficient access to dental services for different age groups.		Partially Met

Comments:

BCFP has made significant strides in late 2005 and early 2006, to correct general dental access standard deficiencies from 2005. Wellpoint Dental Services became the subcontractor for all HUSKY dental services effective 11/1/05. Documents provided during the review included CAPs and evaluations of remedial activities to enhance the dental network. Recruitment strategies have significantly expanded the dental network across the State for both general dentistry and orthodontia. During the review, all monitoring documents submitted appeared to be related to general dentistry and not to orthodontia.

BlueCare Family Plan dental access is monitored by random 'secret shopper' telephone calls to at least 20 groups per month. Providers must meet at least 85 percent for compliance. Tracking sheets demonstrate 100 percent compliance. However, there is no indication of any calls not being answered, or wrong numbers, or anyone being too busy to talk, or not having timely appointments – all issues which routinely occur during these type of phone calls. A number of providers had closed panels, but were compliant for appointment timing for current members. In contrast, in 2005, BCFP also conducted HUSKY 'secret shopper' phone calls to dental provider offices. The results of these calls demonstrated that new members may have difficulty in finding appointments in a timely manner secondary to unavailability of timely appointments. The reports did not indicate any follow-up from Provider Relations to resolve issues. Additionally, BCFP does monitor General Dentistry/Specialist Not Available Inquiries from members. Through October, 2005, they had received 338 calls from members needing assistance in finding an available specialist or general dentist.

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings

Recommendations:

Continue with dental network recruitment strategies.

Conduct dental network adequacy monitoring for orthodontia services.

Review methodology differences between BlueCare Family Plan 'secret shopper' calls and those done for HUSKY as findings conflict with each other and with the number of phone calls from members needing assistance in finding available dentists/specialists.

Reports of survey activities should include follow-up information about health plan activities initiated to resolve outstanding issues.

Prior to conducting a member or provider survey, the MCO should submit a copy of the survey tool and the proposed methodology/protocol to DSS for review and approval.

Compliance with Standards for Timeliness and Access to Services	Analysis	2006 Findings
The MCO shall have systems in place to ensure access to medically necessary and medically appropriate well-care by its Members. The MCO shall develop procedures to identify access problems and shall take corrective action as problems are identified. These systems and initiatives shall include, but not be limited to: monitoring new Members to ensure that a well-care appointment is scheduled within 6 months of enrollment for those whose last well-care visit does not fall within the recommended age appropriate schedules.	New Members receive a New Member Welcome Call during which they are provided information about their benefits and selection of a PCP. BCFP does monitor utilization statistics for outpatient office visits; when issues arise Health Reach conducts telephonic outreach to members to remind them of necessary screenings, immunizations, and well-care appointments	Met
Recommendations: None		

As a component of the EQR, Mercer conducted three on-site record reviews – credentialing, appeals, and CM. CM was reviewed at the request of the State.

Credentialing Files Review

Credentialing files of general and specialty providers (physicians, advanced registered nurse practitioners, physician assistants, and chiropractors) who were terminated either by the plan or who had terminated their contract with the plan during 2005 were reviewed to determine:

- timeliness of credentialing and recredentialing activities;
- completeness of credentialing and recredentialing activities, and
- any evidence to suggest discrimination of the provider by the health plan.

A review of the BCFP credentialing files, reflected a process for credentialing and re-credentialing that was appropriate, timely and complete. All providers had current licenses, board certification inquiry noted when applicable, valid and active DEA numbers when applicable, checks for eligibility for federal programs, documentation of attestation of correctness and completeness of the application by the provider, documentation of primary source verification of education, of disciplinary actions against their license checked, of National Practitioner Data Bank (NPDB) inquiry, and initial on-site visit conducted by health plan with medical record review (MRR) when applicable. There was no evidence of discrimination against individual providers or provider groups.

Recommendations

None

Appeals Files Review

A chart review of 20 member appeals files was performed. Fourteen of the charts (70 percent) were member appeals with an NOA on file. Required timelines in the appeals process were followed in all of these instances, and all members were offered hearing dates at the onset of their appeal.

The format of the NOAs included State-required language that could not be altered, as well as a section that detailed the reason for the denial. Few of the files contained an understandable explanation for the action taken, written in language understandable to a layperson. Generally, there was no information other than "does not meet medical necessity."

Recommendations

- Include sufficient information to members for their consideration in making an appeal decision, using layperson language at the seventh grade reading level.

Case Management/Disease Management Records Review

Ten medical records were reviewed to evaluate CM activities reflecting compliance with coordination and continuity of care. Documentation represented activity and services in 2005 and early 2006.

Documentation in cases show utilization review of requested services with extensive use of home health services for cases with special needs.

CM Case Triggers and Identification: The method for identification of cases for CM came from multiple sources including UM nurses, hospital CM referral, and transplant program coordinator referral. All referrals were timely and appropriate.

Assessment and Care Plan: Cases included a well-documented, complete initial assessment providing the reviewer with an excellent overview of the members' health status and their service needs. Only half of the charts reviewed had a written plan of care. There was good documentation of plan reassessment at appropriate intervals when a plan was written.

Treatment Goals and Progress: The documentation system did provide a mechanism to document behaviorally specific goals and document progress made toward achieving goals. Three quarters of the files demonstrated the presence of long term goals for members and one-third had short term goals in evidence. When goals were present, the documentation showed that there was continuing evaluation of them and that they were modified to match the progress of the member.

Coordination of Resources: All cases reflected referral to medical resources, BH, community services and support groups, home health, transportation, and physicians. Coordination of benefits was well-documented.

Education: Documentation did include some evidence of distribution of education materials about the CM program or disease specific educational material aimed at prevention or improved self-management of the disease process, but more documentation of these activities is needed.

Recommendations

- Develop a monthly peer review auditing process for education and feedback purposes. Audits should focus on:
  - care plan development,
  - writing behaviorally specific goals, and
  - documenting education contacts and interventions – specific telephone contacts and mailings (date and content).

- ned for 2006 based on the analysis.