NAVIGANT

Final Report

External Quality Review:

Blue Cross Blue Shield of Wyoming

CHIP Plan

Technical Report for 2018

Presented April 2019

Prepared for:

Wyoming Department of Health

Contact:
Andrea Pederson, Managing Director
1201 3rd Avenue, Suite 3320
Seattle, Washington 98101
206.292.2569
andrea.pederson@navigant.com

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Wyoming Children's Health Insurance Program (CHIP) provides health coverage to eligible children through Wyoming's Division of Health Care Financing at the Wyoming Department of Health (WDH) in a sole source contract to Blue Cross Blue Shield of Wyoming (BCBSWY) to administer the program at a full risk capitation rate. In accordance with the United States Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) rule, WDH contracted with Navigant Consulting, Inc. (Navigant) as the External Quality Review Organization (EQRO) to conduct the four mandatory EQR activities (Protocols 1-3 and the Network Adequacy Review) in a manner consistent with the protocols established by CMS. Navigant conducted the SFY 2018 EQR of Blue Cross Blue Shield of Wyoming (BCBSWY) for the Kid Care Children's Health Insurance Program (KCC). The purpose of the evaluation is to assure that each contracted Managed Care Organization (MCO) is providing quality services for its Medicaid members in accordance with the CMS Protocols as published in the Code of Federal Regulations (CFR) (42 CFR §433 and §438; Medicaid Program, External Quality Review (EQR) of Medicaid Managed Care Organizations). At the request of WDH, Navigant performed four mandatory activities for EQR as set forth in 42 CFR § 438.358:

1. Assessment of Compliance with Medicaid Managed Care Regulations
2. Validation of Measures Reported by the MCO
3. Validation of a Performance Improvement Project (PIP)
4. Validation of Network Adequacy

The purpose of these activities is to provide review of the quality, timeliness of and access to the services included in the contract (statement of work (SOW)) between WDH and BCBSWY. The tools and methods Navigant used to evaluate each of the protocols is included in sections of this report and its appendices.

It should be noted that this is the first EQR that the state of Wyoming and BCBSWY have ever undertaken. Although WDH has provided CHIP services by contract with BCBSWY for nearly 15 years, the program was only recently deemed a managed care program by CMS (see Section I below). Both WDH and BCBSWY have historically viewed KCC as a Fee for Service Medicaid program[1] and previous contracts between the two entities were written as Administrative Services Agreements- even though a full risk capitation rate was paid by WDH to BCBSWY. With less than 5,000 enrollees statewide, KCC covers a small subset of children; there are over 47,000 children in Wyoming's fee-for-service Medicaid program. WDH does not operate the program under either an 1115 or a 1915 waiver, but rather under the regular statutory provisions for Medicaid that govern the entirety of its Medicaid program for the non-

[1] Wyoming stated in its Title XXI Program Fact Sheet dated 08/12/2010 that: *"The delivery system through which both Medicaid and Kid Care CHIP operate is a contracted fee-for-service model. The penetration rate for managed care systems is low in Wyoming and there is no Medicaid managed care system or a primary care case management program."*
https://www.medicaid.gov/CHIP/Downloads/WY/WYCurrentFactsheet .pdf

waivered populations (see Section 1). The approach, expectations and resources directed at the program supported fee-for-service provisions. Children in the program tend to be of low to moderate risk in terms of overall health complications, and the requirements for case management of this population is generally low. Therefore, the EQR requirements for medical case management, risk management, clinical performance improvement and population health seem to be overly burdensome to both WDH or BCBSWY (whose leadership describe their company as a health insurer versus a managed care organization). The EQR was complicated by the fact that BCBSWY changed its data management vendor and went live on a new data management and claims production platform on January 1, 2019.

Despite these conditions, the results of this review indicate overall compliance by BCBSWY with most of the statutory and regulatory requirements of CMS and the contractual requirements of WDH. It is largely compliant with the statutory provisions in Protocol 1, with minor exceptions. It is also compliant with the Performance Improvement Project (PIP) provisions of Protocol 3, though the PIPs have been in place for many years and are not used as a vehicle to drive continuous clinical improvement, nor do they significantly impact the overall health of the CHIP population (except for the dental PIP). The biggest challenges for BCBSWY was with compliance to Protocol 2. BCBSWY has notable areas for improvement, particularly in data collection, data analysis and clinical quality improvement. These are detailed in Section IV, with recommendations for the future in Section VII.

WDH's contractual expectations for population management and health outcome reporting has been limited. Navigant's review of Protocol 2 was impeded by the data management transition occurring at BCBSWY and its general lack of understanding of the provisions of the protocol in terms of documentation and demonstration of capacity. The challenges of BCBSWY's compliance with Protocol 2 are detailed in this report, and Navigant includes recommendations to strengthen the managed care capabilities of the MCO in the future. WDH and CMS should carefully consider the appropriateness of these recommendations and costs associated with them, given the small population covered by the MCO. Wyoming should continue to evaluate its approach to covering its CHIP population, given the stringent MCO statutory requirements now in force through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

SECTION I. INTRODUCTION

Wyoming's CHIP Program

Wyoming's Division of Healthcare Financing (DHCF) within the Wyoming Department of Health (WDH) administers Wyoming's Medicaid Program. With an overall enrollment of 80,046 beneficiaries in 2018 and an average monthly enrollment of 60,263, Wyoming Medicaid covers 27% of Wyoming Medicaid residents under the age of 20.[2]

On April 5,1999, Wyoming submitted its initial States Child Health Insurance Program (SCHIP) State Plan to establish a separate child health insurance program. In 2018, KCC extended Medicaid coverage to the roughly 4,000 children[3] in families with incomes from 134%-200% of the Federal Poverty Limit (FPL). KCC offers children a separately approved benefit package through BCBSWY. The benefit package includes well-baby and well-child services, immunizations, emergency services, inpatient and outpatient care, prescription drugs, diagnostic services, dental services, medically necessary orthodontics, vision, and inpatient and outpatient mental health and substance abuse treatment and services. There are no premiums or deductibles but there are sliding scale co-payments for services, based on family income. BCBSWY is provided a full risk capitation for beneficiaries by contract from WDH. However, the bulk of children (over 47,000) covered by Wyoming Medicaid remain in its fee-for-service program. In 2018, there were approximately 12,000 uninsured children (0-18 years) in Wyoming. Approximately 3,600 children are 0-133% FPL, while approximately 2,000 children are 134-200% FPL.[4] Table 1 below shows the 2018 FPL eligibility for Medicaid covered children by program.

Table 1: Medicaid Healthcare Coverage for Wyoming Children by FPL

<table>
<tr><td>Children
0-5 years</td><td colspan="3">Medicaid
0-154% FPL
Newborns $900 PMPM, Children (0-18) $235 PMPM</td><td>CHIP
155-200% FPL
$267 Plan A</td><td>Marketplace
201-400% FPL
$452 Premium</td></tr>
<tr><td>Children
6-18 years</td><td colspan="2">Medicaid
0-133% FPL
Children (0-18) $235 PMPM</td><td>CHIP
134-200% FPL
$267 Plan A</td><td>Marketplace
201-400% FPL
$452 Premium</td></tr>
<tr><td rowspan="2"></td><td>0%-50%</td><td>51%-100%</td><td>101%-150%</td><td>151%-200%</td><td>201%-400%</td></tr>
<tr><td colspan="5">Percent (%) of Federal Poverty Level (FPL)</td></tr>
</table>

A brief history of the program and its amendments is provided below (dates are not in sequential

[2] https://health.wyo.gov/wp-content/uploads/2019/01/SFY-2018-Wyoming-Medicaid-Annual-Report.pdf

[3] According to the CHIP annual report filed with DHHE, KCC enrollment in 2018 was4464 and was 3500 in 2019. See https://www.medicaid.gov/chip/downloads/annual-reports/wy-chipannualreport.pdf

[4] Online: http://www.census.gov/did/www/sahie/data/interactive

order, but appear as reported on the CMS website):[5]

- Wyoming submitted its first State Plan Amendment (SPA) on March 6, 2001. This amendment established KCC coverage to children between 134 and 150 percent of the FPL through coverage obtained from eligible employers' plans or from the private health insurance market. KCC never implemented.
- Wyoming submitted its second SPA on June 20, 2002. This amendment updates and amends the SCHIP State plan to indicate the State's compliance with the final SCHIP regulation.
- Wyoming submitted its third SPA on April 1, 2003. This amendment extends coverage to children with family incomes from 134 to 185 percent of the FPL, amends the State's Secretary-approved benefit package, replaces the current Medicaid look-alike benefit package with the amended Secretary-approved benefit package, and implements cost sharing.
- The State submitted its fourth SPA on April 5, 2005. Through this amendment, Wyoming expanded the upper eligibility limit from 185 percent of the FPL to 200 percent of the FPL. This amendment also added additional dental services and increased the annual maximums for dental services, physical and occupational therapy, and services for individuals with speech, hearing and language disorders.
- The State submitted its fifth SPA on April 16, 2007. Through this amendment, Wyoming expanded inpatient mental health benefits from the current twenty-one days per year of coverage to an additional nine days of care per year; changed the current dental benefits to exclude preventative and diagnostic services from the child's yearly benefit maximum; added contact lenses to the current vision benefits and updated the State's current strategic objectives, performance goals and performance measures.
- Wyoming submitted its sixth SPA on May 18, 2009. This amendment makes changes to the State's cost sharing and enrollment procedures, including providing applicants with access to an online application and changing its process for implementing an enrollment cap under its existing State plan authority.
- Wyoming submitted its seventh SPA on June 3, 2010. This amendment complies with the Children's Health Insurance Reauthorization Plan (CHIPRA) mandates for mental health parity and with requirements for medically necessary dental care and orthodontics. The SPA also proposes to meet the alternative payment methodology for Federally Qualified Health Centers and Rural Health Centers.
- Wyoming submitted its eighth SPA on July 22, 2014 to convert the state's existing income eligibility standards to Modified Adjusted Gross Income (MAGI)-equivalent standards by age group for children in CHIP.
- Wyoming submitted its tenth SPA on July 10, 2014 to clarify the state's non-financial eligibility policies on residency, citizenship, social security numbers, substitution of coverage and continuous eligibility.
- Wyoming submitted its eleventh SPA on May 9, 2014 to provide assurance that the state will apply methodologies based on MAGI for all separate CHIP covered groups.
- Wyoming submitted its twelfth SPA March 26, 2014 to provide coverage in KCC for children subject to section 2101(f) of the Affordable Care Act, as specified in the state's submission of CS14: *Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards.*

[5] Wyoming Title XXI Program Fact Sheet 2010- https://www.medicaid.gov/CHIP/Downloads/WY/WYCurrentFactsheet.pdf

Overview of the External Quality Review

In accordance with federal regulations at 42 CFR § 438, subpart E, states must conduct an EQR of contracted managed care entities, including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and primary care case management (PCCM) entities. The EQR focuses on analyzing and evaluating the quality, timeliness, and access to healthcare services provided to Medicaid recipients. An EQR Technical Report must be completed and made available to the CMS and the public by April 30 of each year.

The EQR consists of four mandatory and seven optional activities, as listed in Table 2 below.

Table 2. EQR Activities and Protocols

Activity	
Mandatory	1. Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations
	2. Protocol 2: Validation of Measures Reported by the MCO
	3. Protocol 3: Validation of Performance Improvement Projects (PIPs)
	4. Validation of Network Adequacy
Optional	5. Protocol 4: Validation of Encounter Data
	6. Protocol 5: Administration or validation of consumer or provider surveys of quality of care
	7. Protocol 6: Calculation of performance measures
	8. Protocol 7: Implementation of PIPs
	9. Protocol 8: Focused studies
	10. Assisting with Quality Rating
	11. EQRO technical assistance related to EQR

The mandatory review Navigant completed for WDH is explained in more detailed below:

- EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations**:** States are required to perform a compliance review of each MCO once in a 3-year period to determine the extent to which the MCO complies with federal regulatory provisions, State standards, and the state contract requirements.[6]
- EQR Protocol 2: Validation of Measures: On an annual basis, States must provide to the External Quality Review Organization (EQRO) and the MCO selected performance measures that the MCO must calculate, the specifications for the measures, and State-specific reporting requirements.[7] EQR Protocol 2 evaluates:
    - The accuracy of the selected performance measures based on the measure specifications and State reporting requirements

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

  - The MCO's adherence to the rules outlined by the State Agency for calculating the measures
  - The integrity of the MCO's information system and the completeness/accuracy of the data produced, in accordance with the Information System Capabilities Assessment (ISCA)[8]

- EQR Protocol 3: Validation of Performance Improvement Projects**:** MCO's are required to implement performance improvement projects (PIPs). On an annual basis, the EQRO assesses the validity and reliability of the PIPs.[9]
- Validation of Network Adequacy: The EQR must validate the MCO's network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR § 438.68 which requires the State to develop and enforce network adequacy standards.

Navigant's EQR of BCBSWY is for SFY 2018. It relies on discussions with WDH and BCBSWY staff, documentation provided by WDH and BCBSWY, as well as Navigant's industry experience working with health and human service agencies in 49 states and Washington, D.C.. This report summarizes the findings of the EQR review and provides recommendations for BCBSWY and WDH to improve operational and programmatic performance.

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Appendix V: Information System Capabilities Assessment – Activity Required for Multiple Protocols*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/app5-isassessment.pdf

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

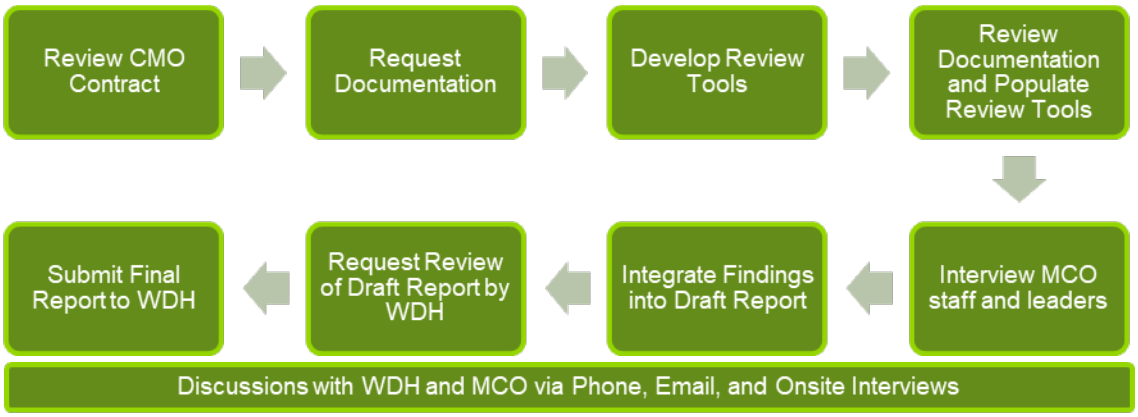
SECTION II. METHODOLOGY

Process of Assessment

Navigant's methodology and associated review tools for all mandatory activities were adapted from the CMS established protocols, approved by WDH and encompassed the following key steps, visualized in Figure 1. The methodology varied slightly for each mandatory activity:

- **EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations:** Relied heavily upon review of documentation and discussions with BCBSWY and WDH by phone, email, and during Navigant's onsite visit**.**
- **EQR Protocol 2: Validation of Measures:** Relied heavily upon review of documentation and validation of data and measurements and interviews and testing during Navigant's onsite visit.
- **EQR Protocol 3: Validation of Performance Improvement Projects:** Relied heavily upon review of documentation and discussions with BCBSWY and Delta Dental during Navigant's onsite visit
- **Validation of Network Adequacy:** Relied heavily upon review of documentation and discussions with BCBSWY during Navigant's onsite visit.

Figure 1. Key Assessment Steps



Review of Documentation

Assessment and validation for this EQR required mapping relevant language from the effective contract between WDH and BCBSWY, herein referenced as the statement of work (SOW), to the Medicaid managed care regulations set forth in 42 CFR § 438:

- **Subpart B** – State Responsibilities
- **Subpart C** – Enrollee Rights and Protections
- **Subpart D** – MCO, PIHP, and PAHP Standards
- **Subpart E** – Quality Measurement and Improvement; External Quality Review
- **Subpart F** – Grievance and Appeal System

After identifying the elements of the SFY 2018 SOW which operationalized the relevant federal code requirements, Navigant requested and reviewed relevant documentation from BCBSWY and WDH including, but not limited to, the following:

- BCBSWY corporate policies and procedures related to quality, timeliness, and access to service and care
- Enrollee and provider handbooks
- Outreach and marketing templates and materials
- Quarterly reports to WDH (including SFY 2018 Quarters 1 – 4, with the Quarter 4 report also serving as the annual report)
- KCC enrollee and provider enrollment processes and policies
- Geographic information on service areas
- Provider agreements for individual and agency providers
- Training for providers
- Wyoming Administrative Rules

Site Visit and Discussions with the MCO

This EQR relied on frequent communication with both WDH and BCBSWY. Key points of contact included:

- Weekly telephone meetings between Navigant and WDH from October 2018 to March 2019
- Weekly telephone meetings between Navigant, WDH, and BCBSWY from January 2019 to March 2019
- Onsite visit to the BCBSWY on February 20-21, 2019
- Ad-hoc emails and meetings

During the onsite visit, the three-member Navigant team met with clinical, operational, and information technology leaders and staff at BCBSWY (see Appendix B for the onsite agenda with the participant list for the onsite meetings) and their subcontractor Delta Dental of Wyoming, as well as with State officials from WDH responsible for the KCC program. Navigant used CMS protocol tools to conduct interviews in the following categories:

- CMC Leadership
- Information Systems and Data Management
- Clinical Quality Performance
- Utilization Management
- Provider Services (including subcontracted pharmacy and vision services)
- Dental Services
- Enrollee Services
- Care Management

To validate performance measures and the technical capabilities of BCBSWY to produce timely and accurate measures and reports, Navigant's experts met with IT staff and spoke with subcontractors to BCBSWY to conduct real time testing of BCBSWY's capability to run reports

and produce measurement. The methodology used to validate the performance measures is described in more detail in the Protocol II Section below, with additional information located in the Appendices.

Scoring and Reporting of Findings

For Protocol One and Two, Navigant used a five-point rating scale consisting of:

- **Fully Met** – All documentation listed under the regulatory provision, or component thereof, is present; and MCO staff provide responses to Navigant reviewers that are consistent with each other and with the documentation.
- **Substantially Met**- In the absence of full documentation, MCO staff can describe and verify existence of compliance practices.
- **Partially Met** –MCO staff can describe and verify existence of compliance practices during interview(s) and/or discussion(s) with Navigant reviewers, but required documentation is unavailable or inconsistent with practice;
- **Minimally Met**- MCO staff have difficulty describing and verifying existence of compliance practices during interview(s) or discussion(s) with Navigant reviewers, and/or documentation is unavailable, incomplete, or inconsistent with practice;
- **Not Met** – Submitted documentation does not meet federal or State standards, or, no documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions.

Protocol Three followed the CMS guideline questions for PIPs, answered as Yes, No or Not Applicable. See Section V for a detailed assessment of Protocol 3.

Appendix C includes a summary of scores for Protocols one, two and three.

SECTION III PROTOCOL I- COMPLIANCE WITH MCO REGULATIONS

Overview

Protocol 1 was used to evaluate BCBSWY's compliance with federal regulatory provisions, State standards, and the WDH/ BCBSWY SOW requirements. Navigant followed CMS's *EQR Protocol 1 Compliance Review Worksheet* to collect information from WDH, establish compliance thresholds, and perform a review of BCBSWY's compliance across the elements applicable to the MCO program.[10] Appendix C includes Navigant's review tool for EQR Protocol 1. Table 3 below provides an overview of BCBSWY's compliance by topic. The compliance review encompassed the following topics:

- ***Enrollee Rights and Protections***: Includes standards to protect the enrollee's right to treatment with dignity and respect. Includes the content and distribution of enrollee materials and compliance with State laws on enrollee rights.
- ***Quality Assessment and Performance Improvement:*** Includes standards for network adequacy (discussed in the Network Adequacy section of this report), timely access to services, delivery of services in a culturally competent manner, coordination and continuity of care, service authorization, provider selection, enrollment and disenrollment, performance measurement and improvement-(discussed in the Protocol 3 section of this report), and health information systems-(discussed in the Protocol 2 section of this report).
- ***Grievance System:*** Includes standards for resolution and notification of grievances and appeals and communication to providers and enrollees regarding the grievance system.

Table 3. Extent of Compliance with EQR Protocol 1 Elements[11]

Compliance Level	Enrollee Rights and Protections		Quality Assessment and Performance Improvement		Grievance System		TOTAL	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Fully Met	7	32%	16	29%	14	64%	37	37%
Substantially Met	3	14%	8	14%	3	14%	14	14%
Partially Met	3	14%	10	18%	4	18%	17	17%
Minimally Met	3	14%	11	20%	1	5%	15	15%
Not Met	6	27%	11	20%	0	0%	17	17%
Total	22	100%	56	100%	22	100%	100	100%

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1 – Assessing MCO Compliance with Medicaid and CHIP Managed Care Regulations Attachment A: Compliance Review Worksheet*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1-attachment-a.pdf

[11] Percentages may not sum to 100 percent due to rounding.

Findings- Noting Areas of Strength and Areas for Improvement

The narrative below provides details on BCBSWY's compliance with federal requirements, by category, noting areas of strength and deficiencies that warrant improvement.

Enrollee Rights and Protections

- **Member Handbook**: Per the WDH contract, both BCBSWY and its subcontractor, Delta Dental of Wyoming (Delta Dental) offer copies of the member handbook in English and in Spanish and address all rights as defined by state statute.

  Strengths:
  - Both contractors provide translation and oral interpretation services free of charge, and BCBSWY provides auxiliary aids at no cost to its members. BCBSWY disseminates information to enrollees through the enrollee handbook and enrollment packet, on the website, and through member services. When discussing how the MCO identified prevalent languages, BCBSWY leadership indicated Spanish speakers and other Native American language speakers comprised less than 2% of the state's population.
  - The BCBSWY and Delta Dental handbooks describe KCC services, benefits, member rights and responsibilities, grievances and appeals, how to choose a primary care provider (PCP), cost-sharing, and contact information.

  Areas for Improvement/Deficiencies:
  - BCBSWY's member handbook scored a Flesch-Kincaid grade level of 9.5, and Delta Dental's handbook scored a 12.5 – neither of which comply with the State's eighth grade level reading requirement.
  - Neither handbook informs members on how to access after-hours care.
  - BCBSWY does not address advance directives as required by CMS.
  - The WDH contract with BCBSWY does not specify the timeframe within which the member handbook must be delivered to members.

- **Provider Directory**: Both BCBSWY and Delta Dental have online provider directories, and paper copies are provided upon request.

  Areas for Improvement/Deficiencies
  - BCBSWY's 45-day timeline for updating the directory does not comply with the CMS 30-day requirement.

- **Information Sharing:** BCBSWY has a member services team that is available during normal business hours via a toll-free number. The team receives calls about benefits, claims, cost-sharing and the provider network, and it shares information with members over the phone, via mail, or in person.

- **Significant Change**: The State has not provided a definition of significant change to BCBSWY, but BCBSWY leadership stated that they notify members if a significant change occurs in the network, particularly for primary care providers and providers who offer services that are not otherwise available.

Areas for Improvement/Deficiencies

- Per BCBSWY documentation, this notification is provided to the member within 45 days of the change, which does not comply with the CFR's 15 calendar day notification requirement. BCBSWY leadership also reported that members are notified of changes in benefits within 30 days.

- **Facility Compliance:** BCBSWY posts member rights information in break rooms and lobby areas of member facilities. All facilities are Americans with Disabilities Act (ADA) compliant. The MCO conducts an annual risk assessment that reviews facility risks, and policies and procedures concerning confidentiality, privacy, access to information in terms of their compliance with the Health Insurance Portability and Accountability Act (HIPAA).

- **Staff Compliance with the MCO's Policies and Procedures as they Relate to Enrollee Rights and Non-Discrimination:** BCBSWY has orientation and annual training requirements addressing privacy and confidentiality as well as a company ethics and compliance manual.

  Strengths:

  - Member services also receives specific training on conducting calls with members. Staff can contact their supervisor to report violations, and BCBSWY listens in on member calls to monitor and ensure compliance. BCBSWY reviews and addresses any issues or violations in its quarterly Quality Monitoring and Assurance Committee (QMAC) meeting.

- **Ensuring Provider/Contractor Compliance with Enrollee Rights:** BCBSWY conducts monthly compliance checks of all databases, including the Officer of the Inspector General. The MCO reports violations and can institute withholds, sanctions, and claw backs depending on the nature of the violation.

- **Addressing and Monitoring Non-Compliance:** BCBSWY has a tracking log for reporting staff violations of enrollee rights, though leadership reported that they had not had any issues reported since the program began.

- **Available Treatment Options and Alternatives**: BCBSWY provides minimal information regarding available treatment options to potential members through its sponsorship of the national curriculum "Healthy Choices" and provides funding for Federally Qualified Health Centers (FQHCs) to offer education on this topic to underserved populations.

  Strengths:

  - BCBSWY has an opportunity in the near future to build a disease management platform within its new information system that it should utilize to support these conversations between members and providers.

Areas for Improvement/Deficiencies

- BCBWY does not ask providers to address available treatment options and alternatives with members and does not monitor any pertinent provider activities.

- **Advance Directives:** Wyoming statute outlines requirements for advance directives.

  Areas for Improvement/Deficiencies

  - BCBSWY does not have any applicable documentation or policies.

- **Notification of Rights of Members:**

  Areas for Improvement/Deficiencies

  - WDH does not require BCBSWY to notify enrollees of their rights to request and obtain information at least once per year.

- **Moral and Religious Objections:**

  Areas for Improvement/Deficiencies

  - WDH does not address moral and religious objections in its contract, and BCBSWY does not have a process in place for providers or members on how such services can be accessed.

- **Consumer Satisfaction:** BCBSWY conducts the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to measure client satisfaction.

Quality Assessment and Performance Improvement

- **Cultural Competency:** The MCO has translation services available for enrollees and providers and includes the Affordable Care Act (ACA Section 1557) notice on their materials, which addresses the fifteen most prevalent languages in Wyoming.

  Areas for Improvement/Deficiencies

  - WDH does not have requirements regarding the delivery of services in a culturally appropriate manner to all enrollees. It was noted to Navigant reviewers that less than 2% of the State's population identified as an ethnic group other than white Caucasian, with the same number identifying as having a primary language other than English. However, no study has been conducted by either WDH or BCBSWY to determine if diverse populations (small as they are) may be disproportionately represented in the KCC program.

- **Coordination of Care for Children with Special Health Care Needs:** BCBSWY works with a vendor to target, track, and communicate with high-risk member populations through phone calls and claims review. The MCO aims to educate these members on health promotion and prevention. It should be noted that given the size and scope of the KCC membership, this is a very small number of enrollees, most children with special needs would qualify for the larger state-run Medicaid program for children, a fee for service system with a larger array of benefits. Perhaps because of this, the contract

between WDH and BCBSWY is not prescriptive regarding children with special health care needs.

Areas for Improvement/Deficiencies

- The State does not have a definition to identify individuals with Special Healthcare Needs (SHCN) and has not prescribed how BCBCWY should identify, screen, or assess these members. Consequently, BCBSWY does not define this member population, or track SHCN members through the Health Risk Assessment (HRA) screening, which is offered to all members upon enrollment but not required.

- **Medical Case Management:** WDH does not require BCBSWY to link enrollees with primary care providers (PCPs). Members are permitted to see a specialist at any time without a referral. BCBSWY's care coordination team will provide care coordination to any member that requests clinical assistance, but for the most part, case management occurs primarily for members identified in one of the PIP populations.

  Strengths:

  - After a member visits a provider, BCBSWY follows up with the provider to try to establish a PCP relationship. The MCO also promotes the advantages of the PCP relationship through its newsletters and welcome packet.

  Areas for Improvement/Deficiencies

  - BCBSWY does not require members to have a PCP.
  - Treatment plans are not required except for special cases.
  - There is no real correlation between HRA results and care coordination.
  - BCBSWY does not track Emergency Room utilization, even though the utilization management (UM) team indicated that a large number of members utilize emergency rooms and urgent care centers due to availability.

- **Provider Selection and Non-Discrimination:** All providers are subject to BCBSWY's extensive credentialing process, which meets State requirements and includes an application; review of education background; and primary source verification of trainings and licensures, work history, malpractice, and liability. The MCO reviews the national practice database, the Office of Inspector General (OIG) and Medicaid Fraud Control Unit (MFCU); and it uses the Bridger solution with Lexus Nexus to ensure that providers have not violated any state or federal laws. Recredentialing is conducted every 3 years. The MCO's credentialing committee meets quarterly to review those applications that have been denied and monitor its network needs. As Wyoming is an "any willing provider" state, BCBSWY only denies providers that do not meet application criteria.

- **Coverage and Authorization of Services:** Interviews with BCBSWY leadership and UM staff demonstrated familiarity with the State's timeframes for standard and expedited requests; however, documentation submitted by the MCO and website information indicated timeframes for standard requests that were not in compliance and contradicted staff interviews. Authorizations for pharmacy benefits flow through the MCO's Pharmacy Benefits Manager (PBM), Prime. BCBSWY monitors this activity, including number of appeals and denial rates. While BCBSWY was able to describe this process in person, the MCO did not provide any reports or dashboards for review.

Strengths:

- BCBSWY submits a monthly report to demonstrate compliance with the state-required timeframes.
- While the UM staff does not consult with the provider during the decision-making process, the MCO has a peer to peer process in place, and providers can discuss questions with the Medical Director before issuing a denial.
- Prior to BCBSWY's new system, the UM team conducted interrater reliability testing internally and through McKesson InterQual monthly. Within the new system, the MCO can review authorizations by Current Procedures Terminology (CPT) code and identify outliers. Trends are discussed at monthly medical policy meetings.

Areas for Improvement/Deficiencies:

- The MCO should update its documentation to match both the State standard and its internal standards.
- BCBSWY does not have practice guidelines beyond services that require pre-authorizations and criteria for residential treatment that mirror McKesson guidelines.
- BCBSWY does not ask providers to address available treatment options and alternatives with members.

- **Enrollment and Disenrollment:** KCC is a mandatory enrollment program with one managed care entity providing services. Enrollment is processed through the State and sent to BCBSWY. If BCBSWY receives a request to disenroll, it refers the member to the State. The State does not require BCBSWY to track disenrollment data.
- **Sub Contractual Relationships and Delegation:** BCBSWY contracts out dental, vision, and pharmacy benefits to Delta Dental, Davis Vision, and Prime respectively. The MCO has a comprehensive vendor management policy that dictates all subcontractor activities, and BCBSWY works closely with its vendors to ensure compliance. No risk arrangements, financial incentives or contractual utilization thresholds exist between BCBSWY and its subcontractors, therefore eliminating the need for BCBSWY to manage the risk of perverse incentives that might limit care to a member. BCBSWY engages in the following activities to manage its vendor relationships pursuant to CMS regulations:
  - **Davis Vision:** As of January 1, 2019, Davis Vision provides telephonic and web-based customer services for BCBSWY's vision benefit. BCBSWY is currently working with Davis to develop its provider network through analysis of member location and optometrist availability to ensure adequate coverage. The two entities are also contacting members who have previously seen an out of network provider and offering a list of network providers. BCBSWY is responsible for all vision-related marketing materials.
  - **Delta Dental:** Delta Dental provides the full range of dental benefits as required by the CHIP program. The contractor is responsible for its network development and is working to enroll 100% of its Wyoming network of dental providers for

children into the KCC network. Delta Dental receives an enrollment file from WDH weekly (with daily updates) and processes changes at least two times per week. It prints and distributes ID cards and enrollment packets and sends them to BCBSWY, to include in the enrollment packet mailed to the member. All of Delta's office staff are trained on the CHIP program and have the ability to review member information, as the contractor does not have a separate call center. Delta Dental conducts weekly meetings to address member issues and bi-weekly meetings to address provider concerns.

- **Prime:** Prime oversees the pharmacy dispensing network, though BCBSWY has ultimate authority of the network. According to BCBSWY's pharmacy directory, every pharmacy in the State has been in the Prime network and only a few hospital outpatient pharmacies do not currently participate. BCBSWY contracts with these dispensaries separately. Complaints about the network are routed through Prime, and BCBSWY does not monitor complaints about network or authorization; however, BCBSWY is involved in the development of Prime's utilization policies and procedures. Prime provides a list of available drugs and pre-authorizations on its website. Providers send in pre-authorization requests and appeals to BCBSWY's pharmacy director for review.

Strengths:

- As a component of its URAC accreditation, BCBSWY has a vendor management program that establishes guidelines, risk identification and stratification, and monitoring. BCBSWY leadership reported that the MCO conducts an annual performance of its vendors using a standardized template, though this was not submitted to Navigant for review.

Grievance System

- **Right to a State Fair Hearing:** BCBSWY notifies members of their right to a state fair hearing in its explanation of benefits.

  Areas for Improvement/Deficiencies
  - BCBSWY does not provide details to its members regarding this right.

- **Grievances:** BCBSWY has grievance policies and procedures for both providers and members. Members are notified of the grievance process – including all timeframes – in the explanation of benefits and can request a form to initiate this process.

  Areas for Improvement/Deficiencies
  - BCBSWY does not inform members that they can also file grievances with the State.
  - BCBSWY leadership indicated that the State approved the MCO's grievance system but did not submit documentation of this approval.

- **Appeals Process:** Members and their authorized representatives, including providers, are permitted to file an appeal. BCBSWY notifies members of their right to appeal and provides a detailed description of the standard appeal process – which has one level appeal before the state fair hearing – in its explanation of benefits.

  Areas for Improvement/Deficiencies
  - MCO does not address expedited appeals in the explanation of benefits or inform members of timeframe to provide evidence for their appeal.
  - BCBSWY did not provide a copy of its notice of adverse benefit determination for review.

- **Determination Notification Timeframes:** Determinations for expedited and standard appeals are provided in a letter to the member within the required timeframes. Per the 2016 managed care rules, federal regulations require the MCO to make standard determinations within 30 days. BCBSWY meets this requirement even though state statute allows for 45-day notice of determination.

  Areas for Improvement/Deficiencies:
  - WDH should contractually specify the CMS 30-day requirement since the state statute is less stringent.

- **Requesting Medical Records:** If a member requests records, member services explains that this is a member right and the file is provided free of charge. Member services sends the request to the legal team to compile and provide documents. While member services do not have a specific timeframe for this process, legal must provide the documents within 30 days.

- **Monitoring and Tracking:** Grievances and appeals are tracked via an internal log and reported to the State. They are also reviewed quarterly by an internal committee.

- **Qualifications and Credentials of Decision-Makers:** The MCO's policies identify that individuals with the appropriate credentials and licensures conduct appeal determinations.

  Strengths:
  - The process described by BCBSWY's medical leadership was clearly articulated, high touch and very accessible to the providers.

SECTION IV. PROTOCOL II- VALIDATION OF MEASURES

Overview of Methodology

EQR Protocol 2 evaluates the accuracy and appropriateness of performance measures reported by BCBSWY and the extent to which the performance measures follow WDH's specifications. Additionally, this section assesses the integrity of BCBSWY's information system and the completeness and accuracy of the data in accordance with the Information Systems Capability Assessment (ISCA) (see Appendix E), a tool created by CMS that each MCO is asked to complete to provide information and an attestation of their information systems capabilities. Navigant assessed the general integrity of BCBSWY's information system and generation of performance measures. Navigant's assessment of the information system relied on review of BCBSWY's partially completed ISCA worksheet, a review of submitted policy and procedure documents, onsite interviews with BCBSWY's information system leadership and staff (see Appendix B for additional information). Documents reviewed for this protocol included:

- Partially Completed ISCA
- Independent Audit of Highmark's HM Health Solution (HMHS) System
- Disaster Recovery and Business Continuity Plan Deliverable Comment Log
- Data Management for Blue Cross Blue Shield of Wyoming document
- Conversion Timeline
- Performance Measure Query Steps
- Performance Measure Flowchart
- T-MSIS Weekly Status Meeting Minutes
- 2015 and 2016 Core Measure Reporting
- Member Database Billing File
- CHIP Enrollment Manual
- Collections P2 Document
- History of Data Management PowerPoint
- Data Management Word File
- OSCAR Claims Flow
- Workflow Bubble Chart
- Project Schedule
- Contingency and Continuity Plan

Validation of Measures Contractually Required by WDH:

CMS requires the EQRO to validate the MCO's ability and compliance in delivering the operational data specified in the MCO contract Scope of Work (SOW). The BCBSWY SOW includes two types of requirements and performance measures:

- **Operational Requirements:** The SOW outlines several operational requirements and associated performance measures.
- **Quality (Outcome) Measures:** The SOW identifies reports that contain specific measures (see Task #19 of Table 3). BCBSWY reports on contractual measures to WDH quarterly, semi-annually, and annually, as specified for each measure. In FY 2017, Wyoming voluntarily reported 10 of the 20 frequently reported quality measures in the CMS Medicaid/CHIP Child Core Set to CMS.

Table 4, on the next page, summarizes the relevant Operational Requirements/Measures in the SOW and the summary finding of Navigant regarding compliance. Compliance findings are scored as follows:

- **Yes**: Reported data meets all established requirements associated with the measure(s).
- **No**: Reported data did not meet established requirements associated with the measure(s) or did not provide sufficient data to meet the requirements.
- **ID:** (Insufficient Data): Documentation provided to Navigant was insufficient to evaluate compliance.

Table 4: A Summary of 2018 Operational Contractual Requirements Related to Protocol 2

	SOW Task #	Description	Date	Score	Comments
Operational Requirements/ Measures	3	Contractor shall submit a Disaster Recovery and Business Continuity Plan...(which)must address recovery of business functions ..technology infrastructure and the process for restoring operations...shall provide disaster recovery and business continuity services, including offsite storage capability.	By 7/13/18	Yes	BCBSWY maintains a disaster recovery plan with strategies for confirming business continuity in case of catastrophic events. BCBSWY replicates data to a secure remote site and recovery teams can access the site remotely to restore business critical operations. BCBSWY performs "rehearsals" or tests to confirm the disaster recovery plan.
	4	Contractor will submit a Monthly Status Meeting. Template should include, but not limited to Action Log, Issues Log, Claims Review Performance Report,	monthly	Yes	Monthly reports are submitted to WDH and reviewed at Monthly status meetings.

	SOW Task #	Description	Date	Score	Comments
		Risk Log, Pre-authorization Report, Enrollment Packet Distribution Report, Customer Service Center Performance Metrics, Provider Disenrollment Report, Inquiry Response Timeliness Report, and any other report identified as necessary.			
Operational Requirements/ Measures	11	The Contractor shall receive an enrollment batch enrollment file from the Agency at least weekly and transmit that same batch file to any appropriate subcontractor, with 99.9% accuracy.	24 hrs. from receipt, 48hrs. for pharmacy	Yes	BCBSWY processes reconciliation file from state once a week. It is incumbent upon the state to maintain unduplicated member records as these just flow through into BCBSWY's system. BCBSWY does integrate the file for members with duplicate SSNs (as an example) to prevent adding duplicative members to their file.
	12	The Contractor shall accept approved enrollment information from the Agency in a manner that is compliant with HIPAA and all federal and State confidentiality rules and regulations.	24 hrs. from receipt, 48hrs. for pharmacy	Yes	See comment above.
	13	The Contractor shall process enrollment of daily add-on children within 12 hours of receiving the add-on enrollment form from the Agency. The Contractor will notify subcontractors, including pharmacy services, of the additional enrollee(s).		Yes	
Operational Requirements/	39	The Contractor shall develop and maintain a Risk Management Plan, including but not limited to, roles and responsibilities, risk management approach and risk identification, risk response	By 7/31/18	Yes	Though the review of this plan was beyond the scope of Protocol II, BCBSWY has developed a Risk Management Plan, which was submitted to WDH. The plan was reviewed as part of an independent audit (conducted by BDO 3/18) of

	SOW Task #	Description	Date	Score	Comments
		strategies and monitoring. The Contractor will include a Risk Management Log as part of the Monthly Status Meeting Reports.			HMHS and no exceptions were noted.
	40	The Contractor shall develop and maintain a comprehensive Security Plan that indicates role-based classifications, NIST compliant, HIPAA security protocols, industry standards for interfacing, Disaster Recovery protocols, limited personal confidential information, preventive controls, detective controls, corrective controls, and security standards compliant with healthcare industry, federal and State standards. The Security Plan will include changes as a result of collaboration with HMHS.	By 8/31/18	Yes	Though the review of this plan was beyond the scope of Protocol II, BCBSWY has developed a Security Plan, which was submitted to WDH. The plan was reviewed as part of the BPD independent audit of HMHS and no exceptions were noted.
	41	The Contractor shall ensure security is in place to protect the confidentiality, integrity and availability of the system and data including data *at rest, in motion, in use, in transport and disposed* data from unauthorized access, use, disclosure, modification or destruction in compliance with federal law and shall ensure that all third-party products, utilities, DLLs and tools are secure and integrated using secure practices. (additional terms and penalties are specified).	Notification within 30 days of any breech according to terms and specifications	Yes	See comment above
	44	The Contractor, or Contractor's vendor, shall meet all federal T-MSIS reporting requirements as per the CMS State Technical Requirements for Preparing T-MSIS Files, Version, 2.0 incorporated by this reference, including the T-MSIS Data	90 days	ID	According to submitted meeting minutes between BCBSWY and WDH, BCBSWY has been actively working with WDH and has a workplan in place to complete the project within 90 days of is HMHS implementation (by 4/1/19).

	SOW Task #	Description	Date	Score	Comments
		Dictionary Version 2.0. with 99% accuracy.			
	45	The Contractor, or Contractor's vendor, shall design, develop, and implement information technology capabilities to transmit operations, performance and quality data as prescribed by T-MSIS as per the CMS State Technical Requirement for Preparing T-MSIS Files, Version 2.0 incorporated by this reference.	No later than 10 prior to go live submissions date to demonstrate operational readiness.	ID	See comments above.
Operational Requirements/ Measures	46	The Contractor, or Contractor's vendor, shall provide the ability to securely interface with CMS for transmission of accurate T-MSIS encounter data and historical data back to October 2015.		ID	See comments above.
	47	The Contractor will provide and maintain a T-MSIS project work plan that includes scheduled tasks, activities, duration, sequencing, dependencies, a plan for each deliverable, completion dates, milestones, entrance and exit criteria and a resource plan.	By 7/10/18 and updated as needed	ID	See comments above
	48	The Contractor shall retrieve the Agency T-MSIS file from a specified location and at a specified time on a weekly/monthly basis. The specified location, time and duration will be determined once T-MSIS goes live.	Daily	ID	See comments above
	49	Contractor shall meet the T-MSIS go-live deadline as required by CMS.	No later than 10 days prior to T-MSIS submission date to demonstrate operational readiness	ID	
	50	The Contractor shall submit to the Agency documentation	15 business days prior to	ID	WDH and BCBSWY continue to work closely on the implementation of the

	SOW Task #	Description	Date	Score	Comments
		including testing results, demonstrating the transition to the HMHS system will not negatively impact the KCC operations including but not limited to timely enrollment of enrollees, payment of claims, reporting and T-MSIS file transmissions to CMS. The Agency reserves the right to reject the proposed transition date if the Contractor is unable to demonstrate operational readiness.	scheduled transition date.		HMHS system. There have been some problems, which are in the process of being resolved between the two organizations and the provider community paid by BCBSWY.
	51	The Contractor shall submit encounter data to the Agency upon MMIS/WINGS Enterprise becoming fully functional. Contractor will submit encounter data on an agreed upon timeline. The encounter data shall meet specified form and content standards and criteria for accuracy as per CMS Medicaid and KCC Managed Care Final Rule (CMS 2390-F) incorporated by this reference.	Per mutually agreed upon timeline after full functionality.	ID	This is still under development, so it is not yet met and would need review in next year's EQR.
Operational Requirements/	52	The Contractor will deliver a Monthly Status Reports five (5) business days prior to the scheduled monthly status/contract management meeting to include accurate metrics on achieving requirements and performance standards described in the Contract.	Monthly	Yes	This occurs monthly
Operation and Quality Outcome	19	The Contractor shall develop, maintain, and deliver to the Agency reports to include specific claims data (by client and/or service) and payment amount and expenditures. Contractor will notify any subcontractor which of the reports/data	Specified by Measure-weekly, monthly, quarterly, semi-annually or annually.	Yes	The validation of WDH selected measures for the purposes of this report is found in the section below: Validation of Selected Measures Reported by BCBSWY A review of monthly, quarterly, semi-annual, and annual reports submitted from BCBSWY to WDH demonstrates

	SOW Task #	Description	Date	Score	Comments
		they need to report. Contractor must be able to furnish daily, weekly, monthly, quarterly, semi-annual, and annual reports to include at a minimum those listed below: • Actuarial and Utilization • Period Summary • Maternity • Benefit Limitations • Wellness Reports • FQHC and RHC Reports/PPS Payments • Provider Network • Membership by Age • Enrollment by Age for Immunization • Pharma Payment After Cancellation Report • Monthly Status Reports • Kid Care CHIP Annual Reporting Template (CARTS) • Child Core Measure Report for CMS • Semi-Annual Report • Annual Report Contents of the Semi-Annual and Annual Reports will be determined by the Agency.	SFY or CY as specified by measure.		general compliance with the contractual requirements for reporting in Task 19, ***though the validation of measures contained in those reports is beyond the scope of this EQR***. Appendix E contains a table listing all the reports and measures produced by BCBSWY that are submitted to WDH.
Quality Measures	20	The Contractor shall develop and maintain a Quality Assurance/Quality Monitoring Plan, including identification of those enrollees who have special health care needs. The Plan will include processes for case management, catastrophic case management and disease management procedures.	By 8/31/18	Yes	The Plan is titled Quality Management Program Description. It was originally developed on 1/14/14, revised on 1/26/16 and most recently reviewed and accepted by BCBSWY leadership on 1/28/19. It does not include identification of enrollees which special health care, which are not necessarily represented in the KCC program.

Assessment of Operational Data Management Capability

Navigant reviewed the ISCA that was provided by BCBSWY (whose answers were incomplete-see Appendix E) as well as other documentation provided by BCBSWY and its vendors. It also conducted an onsite review of BCBSWY's systems and capabilities to assess the overall capability of BCBSWY with regards to performance measurement and operational capability. BCBSWY also provided a recent system audit (March 31, 2018) conducted by BDO. That audit contained no major findings. However, since BCBSWY did not fully complete the ISCA, and because there were several documents that they did not furnish for the EQR, Navigant's review of their systems capacity is incomplete in this report.

BCBSWY uses a mix of in-house and contracted IT services. BCBSWY does not have in-house programmers or developers. As previously described, BCBSWY contracts with HMHS for claims processing and IT services. The contracted pharmacy benefits manager, Prime, processes drug claims for BCBSWY and Delta Dental processes the KCC dental claims through a subcontract with BCBSWY. Davis Vision processes all vision service claims on behalf of BCBSWY.

BCBSWY's operations team performs most operational functions, such as member processing, provider enrollment, claims entry, claims resolution, and reporting using in-house teams. Historically, BCBSWY generated KCC clinical outcome measures once a year for WDH's use in its annual report. BCBSWY appropriately documented processes to support claims adjudication and reporting, including documentation which supported the following processes:

- **Technology—**BCBSWY processes claims on HMHS system. Claims are loaded into the CDM for reporting—this repository contains claims processed after 1/1/19. BCBSWY has access to BCBS of North Dakota's reporting repository (ORACLE), which contains claims processed on their system prior to 1/1/19. HMHS is building an Enterprise Data Warehouse (EDW) for BCBSWY The EDW is built from Cognos. This system will contain historical claims (processed by BCBS of North Dakota) and claims processed in HMHS system. Separately, BCBSWY also has access to HMHS's reporting tool, the Client Data Mart (CDM). BCBSWY plans to use the new EDW for reporting after its implementation, which is scheduled to have both sets of claims available in April 2019. At the time of the EQR site visit, BCBSWY was unable to demonstrate measure creation, since the system is still being built. The measure validity reported in this EQR was based on code from the historical (Blue Cross Blue Shield of North Dakota) system.
- **Claims adjudication, editing, and processing—**BCBSWY appears to process claims in a timely and accurate manner. They use best practices for claims resolution. Providers may submit either paper and electronic claims to BCBSWY. Paper claims are electronically imaged onsite using Optical Character Recognition (OCR). BCBSWY's suspense correction staff work suspended claims according to their online desk-level procedures. The EQR review team observed staff working claims during the onsite visit. Desk-level procedures for several suspended edits were reviewed. Each edit contained detailed instructions that would guide the corrections team on how to resolve the edit. We consider this a best practice.

The BCBSWY corrections team leaders attested that the post-payment auditing process demonstrated that about 99% of all claims are processed correctly. Additionally, leaders attested to the fact that that BCBSWY paid 90% of all claims within 30 days. There were some temporary delays in claims processing and payments with the conversion to the new HMHS system in January 2019, causing BCBSWY to miss certain contractual obligations regarding timely payment. Those issues seem to be largely resolved.

- **Disaster recovery plan—**BCBSWY maintains a disaster recovery plan with strategies for confirming business continuity in case of catastrophic events. BCBSWY replicates data to a secure remote site and recovery teams can access the site remotely to restore business critical operations. BCBSWY performs "rehearsals" or tests to confirm the disaster recovery plan. We consider this a best practice.
- **Member Enrollment—**The team processes a reconciliation file from the state once a week. BCBSWY relies upon the state to maintain unduplicated member records. However, BCBSWY also interrogates the member records (testing for duplicate SSNs as an example) to prevent adding duplicative members to their file.
- **Provider Network—**BCBSWY maintains an independent provider file independent of the state's enrolled providers.

In general, the EQR reviewers found that BCBSWY has the capacity to manage its claims related operations and provider payment functions quite well, meeting or exceeding CMS requirements and WDH's contractual expectations. While the migration from one data manager to another has created some short-term problems for the MCO, these are being resolved and the capacity of the new vendor should give BCBSWY additional capacity in key areas where weaknesses were noted- specifically in the areas of clinical quality outcome measurement, case management, and data analytics. These are critical areas for improvement for BCBSWY as it moves toward building its care management capacity versus the capabilities needed as simply a health plan administrator. Given the small size of the KCC program and the overall relative health of its members, these clinical competencies have not been as critical as they might be if BCBSWY were managing a more clinically complex population of Medicaid members for the state of Wyoming. Should Wyoming venture into Medicaid Managed Care for these more complex populations in the future, such capacity would be critical for BCBSWY to be viewed as a highly capable participating plan.

Assessment of Capability in Clinical Outcomes Measurement

In evaluating the measures selected for data validation, Navigant found the process for BCBSWY's derivation and review of performance measures for the KCC program lacked rigor. BCBSWY does not have appropriate levels of training for staff assigned to generate measures and reports. Historically, staff have used Microsoft (MS) Access to generate measures and are not trained in Standard Query Language (SQL), which would have helped them create valid measures and aided them in verifying measurement accuracy. Historically, the measures requested by WDH have been compiled by a one staff member, who has singularly determined the algorithm to produce the measure, compiled the report and passed it along for submission to WDH. There is no documentation on the quality controls used by staff to verify performance

measures after creation. There is no documentation on the internal controls related to the approval of measures internally. When asked to explain the process by which measures were approved, BCBSWY could not articulate their internal processes for measure approval. The strategy for reviewing performance measures could include, for example, comparing the measure results to previous years measure results, peer reviewing selection code, comparing results to national benchmarks, or other controls. But this review does not take place. While dental measures were not in scope for this review, we interviewed BCBSWY's Dental vendor, Delta Dental, who creates dental performance measures. In their process, the code used to produce the outcome measures is peer reviewed and results are compared to reports for prior time periods. Any data that looks unreasonable is re-evaluated. A final review of the measure is made by the President of Delta Dental before submission to BCBSWY. BCBSWY is in the process of setting up an analytics-focused Informatics team, and their plan is to use some of those resources to create performance measures in future years.

Validation of Selected Measures Reported by BSBSWY

CMS requires states to specify the measures that the EQRO is to validate. WDH requested that Navigant validate a subset of the CHIP core measures listed below. Navigant's validation included review of reports of measures provided by BCBSWY, a review of the methods used to produce the measure and a test of their ability to aggregate the measures in real time. This task was complicated by the fact that BCBSWY changed its IT platform on January 1, 2019. BCBSWY has historically outsourced its IT claims management system to Blue Cross Blue Shield of North Dakota, which hosted its claims adjudication and data management systems. At the start of 2019, BCBSWY changed its vendor for claims adjudication and related functions to HM Health Solutions (HMHS) a subsidiary of Highmark Inc., which operates Blue Cross Blue Shield insurance plans in several states (Pennsylvania, West Virginia, and Delaware) as well as running clinically integrated networks and providing outsourced business solutions to other health plans (such as BCBSWY) though HMHS. At the time of this review, BCBSWY was still building out some of the functionality it needs to report measures. BCBSWY was also unable to provide all the documentation necessary from its legacy system to allow Navigant to validate its reported FY and CY measures from 2018. This section of the report provides as assessment of the selected measures in terms of validity. The measures selected by WDH did not require a review of medical records or sampling (neither of which is routinely performed by BCBSWY for KCC). In the fall, WDH requested that BCBSWY generate reports on the following measure. A single BCBSWY data analyst then created the outcome measures reports using Microsoft Access connected with BCBSND's data repository.

CHIP Measures Selected by WDH for Validation:

1. ADD: Follow-up Care for Children Prescribed ADHD Medication- was found to be invalid. The numerator and denominator used by BCBSWY to calculate the measure were not consistent with the HEDIS definition. Specifically:

- The denominator did not include ADD visit values, ADD Procedure Code values, or ADD Service Code values codes applicable to ADD visits.
- The numerator did not include ADD visit values, ADD Procedure Code values, and ADD Service Code values codes applicable to ADD visits.
- There was no evidence that all new codes for the Value Set Mental Health Diagnosis (the following ICD-10 codes: F32.81, F32.89, F34.81, F34.89, F42.2, F42.3, F42.4, F42.8, F42.9, F50.81, F50.89, F64.0, F80.82) are now included.
- There was no evidence that all ICD-9 codes for Chemical Dependency and Mental Health Diagnosis were removed per version 2018.1.17AA.
- There was no evidence that new value sets include the Telehealth Modifier and the Telehealth Point of Service (both of which have been added for ADD in 2018).

2. AMB: Ambulatory Care – was found to be invalid. The numerator and denominator were not consistent with the HEDIS definition. Specifically:

   - There was no evidence that the denominator was calculated with the ED visit exclusion imposed. Codes for the Inpatient Stay Value Set were not referenced in the SQL.
   - In calculating the denominator, there was no evidence that the mandatory exclusions were included. It appears that BCBSWY used a non-standard code set ("MISTOS"),values 12, 13, & 14 are derived from provider type—BCBSWY did not test that this exclusion completely mirrored HEDIS exclusion set.
   - In calculating the denominator, there was reference to the following Value Sets: Mental and Behavioral Health Disorders, Psychiatry, Electroconvulsive Therapy, and Alcohol or Drug Rehabilitation and Detoxification (Withdrawal Management).
   - In calculating the denominator, there was no evidence in SQL that "emergency room visit (EMERG) flag was determined by evaluating the following Value Sets: ED and ED Procedure Code.
   - Exclusion does not appear to be implemented as there is no reference to the Inpatient Stay Value Set.

3. AMR: Asthma Medication Ratio: The measure was found to be invalid because the numerator was not consistent with the HEDIS definition. Specifically:

   - The query used to run the report included individuals who had a diagnosis of asthma who should have been excluded (such as individuals with certain chronic respiratory diseases- emphysema, a variety of chronic obstructive pulmonary diseases, respiratory failure and cystic fibrosis and individuals with a diagnosis of asthma who were not prescribed any asthma medication during the measurement period). [12]

[12] HEDIS definition includes: "*"Exclude: Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year: –Emphysema Value Set –Other Emphysema Value Set –COPD Value Set –Obstructive Chronic Bronchitis Value Set –Chronic Respiratory Conditions Due to Fumes/Vapors Value Set –Cystic Fibrosis Value Set –Acute Respiratory Failure Value Set; Members who had no asthma medications (controller or reliever) dispensed during the measurement year."*

4. CHL: Chlamydia Screening in Women Ages 16-20 was found to be invalid because the numerator and denominator were not consistent with the HEDIS definition. Specifically:
   - There was no evidence found in SQL that the individuals selected in the denominator had been determined as sexually active (though evaluating the following Value Sets: Sexual Activity).
   - No evidence that the members included in the numerator were identified as sexually active; this is a requirement in addition to the SCREENED consideration.
   - Queries provided do not appear to reference evaluation of the value sets for Pregnancy, Sexual Activity, or Pregnancy Tests, and there appears to be no reference to the Contraceptive Medications List. The measure requires that each be evaluated, but the member only needs to be identified in one to be eligible.

5. DEV-CH*: Developmental Screening in the First Three Years of Life- the measure was found to be invalid because the denominator was inconsistent with the HEDIS definition. Specifically:
   - There was no indication that claims/provider files include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.
   - Queries “qry_UT_Social_Emotional_01 and qry_UT_Social_Emotional_02 evaluate for procedure code 96110”, was described as "developmental testing, limited", but the DEV-CH measure specifies the denominator criteria is procedure 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02.

6. FUH: Follow-up After Hospitalization for Mental Illness- was found to be invalid, because the numerator and denominator were not consistent with the HEDIS definition. Specifically:
   - There was no indication that the numerator included all new codes for Value Set Mental Health Diagnosis (ICD codes F32.81, F32.89, F34.81, F34.89, F42.2, F42.3, F42.4, F42.8, F42.9, F50.81, F50.89, F64.0, F80.82).
   - The numerator did not remove ICD-9 codes for Chemical Dependency and Mental Health Diagnosis.[13]
   - The numerator did not include the new value set Telehealth Modifier, which was added to this measure in 2018.
   - In “qry_UT_Follow_up_Mental_Illness_Patients_04”, the BETWEEN term is used and means that "DISCHARGE" is currently counted as 1 but should not be (it was excluded in 2018 for this measure). The proper code would read: between the "ADMIT_DT" through the "THRU_DT."

Recommendations

In addition to the observations noted in the assessment sections above, Navigant suggests the following recommendations be considered with regards to Performance Measurement:

- **Selection of Measures**—WDH and BCBSWY should select performance measures that align with clinical and performance goals and should set these measures for multiple years.

[13] Details are available in version HEDIS definitions manual, 2018.1.17AA

Currently, WDH re-selects measures each year in the last quarter of the measurement period. Having a defined set of measures year over year would help BCBSWY focus their quality initiatives and use measure to drive toward continuous quality improvement.

- **Strengthening System Capacity—** BCBSWY should prioritize the completion of its buildout of its EDW, including a thorough and comprehensive testing of imported claims data.

- **Creation and Review of Reports—**BCBSWY should re-evaluate the entire process for generating performance measures. BCBSWY should adopt new processes and procedures to help ensure that measures defined according to each measure steward's (i.e. HEIDIS) specifications. The measures algorithms must be properly validated by qualified analytics staff and IT leadership.

- **Information Systems Staffing—**BCBSWY should continue to build out its informatics analytics team. There should be more than one person who can create measures. Proper supervision, training and lines of authority should be set in place. Specifically, BCBSWY should invest in proper training of their staff in the use of industry standard tools, such as SQL.

- **Data Quality Control**—BCBSWY should review, adopt, and implement proper quality controls for the team creating performance measures. At minimum, the team needs to compare this year's measure results to previous years and conduct a peer review of the code in comparison the measure stewards' specifications.

- **Internal Control Systems—**BCBSWY should create, document, and adopt an internal process to approve measures in-house before their submission to the state. At minimum, this should include approval by Government Programs Project Manager and leadership team.

SECTION V. PROTOCOL III- VALIDATION OF PIPS

Overview

The three PIPs that BCBSWY has undertaken are:

1. EPSTD Screening: To increase the number of KCC children who receive a well child visit or age aligned EPSDT screening.
2. Obesity Management: To reduce the number of KCC who have a diagnosis of obesity and uncontrolled diabetes in order to improve health status.
3. Preventive Dental Screening: To increase compliance with annual dental screenings and EPSDT screenings.

Copies of the PIP reports as reported to WDH are in Appendix F.

Navigant reviewed all documents submitted by BCBSWY related to the PIPS. This included reported results, study definitions, minutes of internal Quality Assurance and Monitoring Committee meetings where PIPs were reviewed and discussed, and data reports and queries used to produce PIP results. Additionally, Navigant interviewed senior leaders responsible for clinical quality at BCBSWY, including its Medical Director, Vice President of Care Delivery and Provider Affairs, Medical Review Manager and Internal Operations Manager as well as staff responsible for preparing reports.

The general assessment of the BCBSWY PIP program is that it is very basic and should be developed with more precision and sophistication in the selection of measures, design of the projects and use of the projects in driving improvement. The one clinically interventional PIP, Obesity Management, does not have a meaningful population focus or approach. The two screening PIPs have been static for multiple years without a strong demonstration of impact in the improvement of the health of the population. Validation of measures used for the PIP is limited by the inherent problems with data already noted in Protocol II. While the PIPs fulfill the basic statutory requirements of CMS, they are not used to drive meaningful clinical improvement in the enrolled population, nor are they used to improve the overall population-based case management of the MCO. The team at BCBSWY is very thorough and committed. All PIP data is compiled monthly and reported quarterly. The Quality Monitoring and Assurance Committee of BCBSWY reviews PIP progress on a quarterly basis. The Medical Director is involved in reviewing PIPs with the clinical quality improvement staff. With new tools in the recently installed HMHS system, BCBSWY should be able to focus on PIPs that will assist the organization in improving its overall care delivery though better targeted case management and the ability to produce meaningful reports for PCPs to actively engage their patients and better manage their health.

Assessment of PIPs

1. ***PIP 1- EPSDT Screening: To increase the number of KCC children who receive a well child visit or age aligned EPSDT screening.***

Study Topic: BCBSWY chose this study topic primarily because it is a focused priority for WDH. According to BCBSWY, Early Periodic Screening and Diagnostic Testing (EPSDT) screening and data shows that there is significant room for improvement. EPSDT screening is a valid and meaningful measure consistent with the national data set for preventive exams among children. The study encompasses all enrollees of KCC between the ages of 0-18 years of age. The study has been benchmarked year after year to track and trend overall improvement (or lack thereof). BCBSWY had identified EPSDT screening as an important component of its overall Quality Monitoring and Assurance Plan.

Study Question: BCBSWY did not frame a study question. However, it did identify a focus for the PIP, with the necessary framework for data collection. The lack of a study question has led to vague expectations of improvement in the health of the population. The PIP states that "appropriate well-child checks and preventive screenings provided by EPSDT assure better health outcomes and identification of potential health problems that can be addressed when first identified." There has been no attempt to tie results from EPSDT screening with the Health Risks Assessment data. The goal for the PIP is also vague, stated simply as "increase the number of children receiving EPSDT screening services each year." Improvement for the goal has remained relatively flat year over year, even though various strategies have been used by BCBSWY to increase screening.

Study Population and Study Indicators: The population for the study is clearly defined and encompasses all enrollees in KCC. The study indicators are clearly defined as the percentage of children who had an EPSDT service code with a primary service provider during the contract period and the percentage of providers who used an appropriate EPSDT coding combination in conjunction with a well child service claim. The PIP does not consider enrollees with special health needs per se, though this population is low in the KCC program and this PIP encompasses all enrollees.

Data Collection and Data Analysis and Interpretation of Results: Claims data is used for data collection and analysis.

The data sets collected for the PIP are defined as:

- The percentage of enrollees with a designated primary service provider
- The percentage of providers billing with EPSDT coding
- The percentage of enrollees with an EPSDT service in the calendar year
- A rolling calendar year, quality report of all enrollees who did not have an

EPSDT service in the previous quarter, with cumulative quarters reported for the calendar year.

There is recognition that some PCPs record the code for well visit without using the requisite EPSDT screening codes, though quarterly reports furnished by BCBSWY indicate that 97% of the claims submitted for well child care were billed with the appropriate EPSDT coding combination. This finding is based on appropriate coding for the screening by age, not on a medical records sampling audit. Only one EPSDT screening code or well child visit is required per year, so there is no age-related breakout for this PIP for children birth to two who require multiple visits and screenings in the first two years of life.

Improvement Strategies and Sustainability of Improvement: BCBSWY identifies members who have not had the required screening and intervenes by sending reminder letters to the members through its Case Management department. If members remain non-compliant for two quarters, Case Management activities are initiated, including contacting the member and his/her PCP. Given the relatively low number of enrollees in the plan, BCBSWY has been able to be robust in its outreach to those enrollees that have not had the necessary EPSDT screening.

Validity and Reliability of Study Results:
The data parameters for the PIP were provided to reviewers and the data parameters seem straight forward and correct. The study parameters have not changed year over year.

Areas for Improvement/Deficiencies for PIP #1:

- BCBSWY should be asking questions regarding the overall results and the impact on access to care and the health of its members.
- BCBSWY has not done a study of how many treatable conditions have been identified through EPSDT screening, whether early intervention occurred for identified conditions, what the result of such intervention has been on the overall health of a group of enrollees with the same diagnosis, nor any cost analysis related to the impact of screening and diagnosis on overall health care costs, avoidable hospital admissions or overall health.
- There has been no follow-up to study whether those enrollees who received EPSDT screening had better access to care for identified illnesses than those who did not receive timely screening.
- The goal has not been modified in the many years it has been in place to reflect prior years trends in performance.
- The overall effect of strategies used to improve performance of the PIP has not been trended over time and is not well understood in terms of modifying or revising the PIP.

2. ***PIP #2- Obesity Management:* To reduce the number of KCC enrollees who have a diagnosis of obesity and uncontrolled diabetes to improve health status.**

Study Topic: The number of enrollees involved in this study is quite low relative to the KCC population (less than 5% of all enrollees). BCBSWY's clinical leadership stated that they chose this topic because the overall impact of the burden of disease for this small population of enrollees is high in terms of cost and utilization; and because many of the enrollees with a diagnosis of childhood morbid obesity and uncontrolled diabetes also had a lack of regular engagement with their PCP. However, the goal set for this PIP is vague, stated as: "*Reduction in the number* ***of Kid Care CHIP*** *enrollees with diagnosis of obesity and uncontrolled diabetes to improve the child's health status and reduce further complications."*

Study Question, Study Population and Study Indicators: The PIP states that this "project was selected to improve the health of children who suffer from the complications of uncontrolled diabetes and obesity and who can benefit from targeted outreach." But the study is not framed to address this overall question or goal. The study only includes those enrollees who were diagnosed with both diabetes and obesity (through an aggregation of claims for all active enrollees that have a diagnosis code of obesity, uncontrolled diabetes and/or ketoacidosis). This excludes diabetics who are not obese, and obese enrollees who may be pre-diabetic or have an undiagnosed diabetic condition. The term "morbidly obese" presented in the study topic is misleading, as the study includes all enrollees who have both a diagnosis of obesity and diabetes, not just those who might be considered "morbidly obese" (a term not typically associated with childhood obesity). The study results measure only those who have been identified by the parameters set in the PIP and then remanded to telephonic case management at BCBSWY.

Data Collection and Data Analysis and Interpretation of Results: The only reported result for the PIP is the number of individuals identified in the study cohort and referred to case management. While the individual case management has been intensive for some enrollees, involving peer to peer consultation by the Medical Director and telephone consultation with members and their PCPs, there are no aggregate measures of clinical control (such as Hemoglobin A1c tests) or weight management (such as BMI) for the entire study population. Hence, the PIP can only attest to the anecdotal improvement of a handful of individual enrollees. Because the study does not address roots causes of childhood diabetes or the underlying issue with obesity, the impact of the study is limited in terms of health improvement for the population. There is no discernment between Type 1 and Type 2 diabetes for the aggregated data. Other significant lab values (cholesterol and blood pressure, for example) are not considered in the study.

Improvement Strategies and Sustainability of Improvement: As stated above, the strategy used to address health improvement is intensive case management. The team also instructs member services staff to reach out to cohort participants to provide them with information on diet and exercise. The team intervenes for any member of the cohort who has not identified a PCP. Given the low number of enrollees in the study, this is an effective intervention for each and every case, though the overall population-based strategy for the PIP needs improvement.

Validity and Reliability of Study Results: The simple measure of identifying diabetics for the cohort is not necessarily valid to prove impact of the PIP on the overall health of cohort members. However, the measure is simple, and the calculation is straightforward, based on the presence of diagnostic codes that meet the study definition and run for all enrollees quarterly.

Areas for Improvement/Deficiencies for PIP #2:

- The study excludes enrollees who may be suffering from the complication of uncontrolled diabetes who have not been diagnosed with the condition or who are not obese.
- Given national data on childhood obesity and its relationship to undiagnosed diabetic and pre-diabetic states among children, BCBSWY should consider using a broader topic for its PIP (such as the identification of childhood obesity among the enrolled population and its correlation to the identification of pre-diabetes and undiagnosed diabetes).
- While Body Mass Index (BMI) data is available, and used in individual case management for identified enrollees, it is not aggregated for the population in the study, even once a cohort of enrollees is identified by claims data analysis.
- There are no aggregate measures of clinical control (such as Hemoglobin A1c tests) or weight management (such as BMI) for the entire study population. Without population-based values built into the study, there is no way to compare effective control of diabetes among the enrollees in the study cohort.
- There are no practice guidelines issued to the providers, nor is adherence to best clinical practices monitored outside of individual case review.
- BCBSWY should study national best practices in community-based childhood obesity management programs to improve the focus of this PIP. If the study were broadened to address obesity in KCC's enrolled population a stronger set of interventions could be developed.

3. ***PIP #3- Preventive Dental Screening: To increase compliance with annual dental screenings and EPSDT screenings.***

Study Topic: This study is conducted by Delta Dental on behalf of BCBSWY. It is to identify KCC enrollees who have not received and EPSDT or other pediatric dental

screening in the calendar year measurement period. The topic is relevant to overall dental health, and touches the entire enrolled population, including any children with special healthcare needs. EPSDT screening is a valid and meaningful measure consistent with the national data set for preventive exams among children. The study encompasses all enrollees of KCC between the ages of 1-18 years of age. The study has been benchmarked year after year to track and trend overall improvement (or lack thereof). BCBSWY had identified EPSDT screening as an important component of its overall Quality Monitoring and Assurance Plan.

Study Question: Delta Dental did not frame a study question. However, it did identify a focus for the PIP, with the necessary framework for data collection. The lack of a study question has also led to vague goals and expectations of improvement over time. The stated goal is "to increase the participation rate of children receiving a pediatric dental/EPSDT screening."

Data Collection and Data Analysis and Interpretation of Results: Delta Dental uses claims analysis to identify KCC enrollees who have not received an EPSDT or other pediatric dental screening in the measurement period. EPDST codes demonstrate age appropriate dental screenings. Reports are run in house, code and method are verified by a supervisor and all reports are reviewed by senior staff before submission is made to BCBSWY.

Improvement Strategies and Sustainability of Improvement: There is a very high touch approach employed at Delta Dental of WY in reaching out to its enrollees and participating dentists to encourage compliance with screening. The staff visit schools, hold educational sessions, visit all participating providers at least annually and reach out through member services to those enrollees in need of screening.

Validity and Reliability of Study Results: Delta Dental submits measures to WDH as a subcontractor to BCBSWY for the KCC program. In their process, the code used to produce the outcome measures is peer reviewed and results are compared to reports for prior time periods. Any data that looks askew is re-evaluated. A final review of the measure is made by the President of Delta Dental before submission to BCBSWY.

Areas for Improvement/Deficiencies for PIP #3:

- There is no benchmark or percentage of improvement established in the goal statement, even though the goal has been in place for multiple years and a multi-year baseline is established for the PIP. The PIP does not include a study of the outcome of the screening for the population, nor what percentage of enrollees received and completed any necessary follow up treatment in a timely manner.

SECTION VI. VALIDATION OF NETWORK ADEQUACY

Overview of Method for Assessing and Monitoring Adequacy

The evaluation of network adequacy is part of the overall compliance standards set forth in Protocol I. However, since those protocols were promulgated in 2012 (they are overdue for revision by CMS to come into compliance with more recent statutory provisions for MCOs that were promulgated in 2016), Navigant attempts to address the requirements set forth in 42 CFR § 438.68 for Wyoming to develop and enforce network adequacy standards. Based on these federal and State standards, Navigant identified the following elements as pertinent to BCBSWY's compliance with network adequacy:

- **Time and distance standards:** Wyoming is designated a frontier state. It has not imposed time and distance standards on it MCO due to the rural nature of the state. It does require BCBSWY to do a geo mapping of its network and BCBSWY conducts time and distance studies even though WDH does not require it.
- **Capacity of certain provider types:** There are no contractual obligations imposed on BCBSWY other than the credentialing requirements covered in Protocol 1. Accessibility of the network is discussed below.

Overview of Wyoming's Network Adequacy Standards

Geographic Adequacy:

WDH continues to seek clarification from CMS regarding frontier state designation time and distance requirements. WDH requires that BCBSWY have 80% provider network penetration in every county. BCBSWY meets this requirement except for one county, where the percent of dentists is below the threshold because there is no practicing dentists in the county. The State does not have any additional time and distance requirements and refers to CMS's "frontier designation", which does not define numeric standards for time and distance. BCBSWY runs geo access reports to assess time and distance, availability, specialty, number of patients, and if providers are accepting new patients. BCBSWY also conducts provider survey and phone calls to monitor availability. BCBSWY does not monitor time access standards and does not have a methodology to project the number, type, or location of primary care providers and specialists necessary to serve its anticipated membership. The MCO reviews network adequacy during its quarterly QMAC meeting.

Accessibility:

BCBSWY has contracted with at least one hospital in every county within the State that has an all-hours emergency room, and it has a network of urgent care centers that accept KCC members. BCBSWY does not conduct an analysis to ensure that its network providers' hours of operation do not discriminate against KCC members, which it should consider including in its monitoring activities. Leadership noted that members have not historically complained about

provider discrimination and wait times. BCBSWY does not assess whether its provider network meets preferred language and communication standards for enrollees with limited English proficiency, although as stated in the Section III- Protocol I review, the language diversity in Wyoming is limited to 2% of the entire population (though as previously noted, there has been no attempt to study whether this diversity is disproportionately represented in KCC). BCBSWY provide telephonic language interpretation services to all providers in its network. Most hospitals in the network comply with language and access standards through independent accreditation standards, such as those imposed by the Joint Commission.

Areas of Strength and Needed Improvement

Strengths:

- BCBSWY conducts a quarterly review of newly enrolled providers and monitors network activity to identify and track any areas of concern, specifically focusing on specialty providers.
- 98% of all BCBSWY providers who treat children are in the KCC network
- BCBSWY contracts with virtually all eligible medical providers in Wyoming and boarder communities.
- Delta Dental conducts strong provider outreach to recruit and retain dental providers in the KCC network, visiting 100% of the Wyoming's dentists who treat children at least annually to highlight the program.

Areas for Improvement/Deficiencies:

- WDH should contractually specify standards for network adequacy.
- There are no specified standards for timely access to care and BCBSWY does not set such standards in provider agreements, nor does it monitor for timely access.
- BCBSWY's provider agreement addresses federal and state regulations but does not explicitly address the need for providers to offer physical access, reasonable accommodations, and accessible equipment for children or family members with disabilities.
- BCBSWY does not reimburse out-of-network providers outside of emergency care.
- BCBSWY does not conduct an analysis to ensure that its network providers' hours of operation do not discriminate against KCC members, which it should consider including in its monitoring activities.

SECTION VII. CONCLUSION

Navigant's review of Wyoming's KCC MCO demonstrates that BCBSWY complies with most of the standards set forth in code and regulations pertaining to Protocols 1-3 and the Network Adequacy Requirements of the External Quality Review.

Generally, BCBSWY has adequate systems in place to assure that enrollee rights and protections are safeguarded and communicated via enrollee materials. Its strengths include:

- Good network development policies and procedures which assure a complete and well qualified network for KCC enrollees.
- A very strong relationship with most, if not all, providers in Wyoming
- Prominence as a health insurance plan (in terms of number of covered lives) in Wyoming for decades.
- URAC accreditation.
- Sound operational and financial management.
- A clinical affairs department comprised of dedicated staff who understand the population served and the delivery system across the state.
- Subcontractors serving the MCO are well monitored and policies concerning these vendor relationships are well defined. BCBSWY keeps a hands-on approach with its vendors in provider network development, provider relations and customer service. They get directly involved in the adjudication of complaints and they monitor service delivery, authorizations, and denials appropriately.
- Tight control for fraud protection and strong systems of review of claims and protection of enrollees right to service.
- CAHPs surveys that indicate consumers and providers satisfaction.
- A strong relationship with WDH.
- A credible and capable partner for the KCC program for nearly 15 years.
- A strong member services department, demonstrating the capacity to deliver service to the enrollees and to monitor the overall quality of that service.
- Demonstrated ability and commitment to treat all KCC members with dignity and respect and to do everything possible to assure their access to timely, high quality care.
- Delta Dental consistently goes above and beyond the required activities to promote and advance access to oral health for the KCC enrollees.

Despite some of the typical hiccups associated with any major transition IT systems, BCBSWY and its vendor (HMHS) have worked closely with WDH in the identification and resolution of issues, particularly those that have created delays in service payments to providers. The new system should add managed care capabilities to the MCO that it currently lacks. Most of challenges associated with BCBSWY's compliance with CMS standards lie in the areas of data collection, measurement, and reporting. These have been detailed in Section IV- Protocol II of this report. Some of these issues stem from a lack of capacity in terms of staff, training, and systems capacity. Those should be addressed in a timely fashion and concert with the HMHS vendor.

Most of the issues in the fulfillment of BCBSWY's compliance with CMS standards stem from the historical view of the role of BCBSWY as a health insurer and not an MCO; and from KCC being viewed as a traditional fee-for-service program, with BCBSWY as the third-party administrator. The change in designation by CMS caught both the MCO and WDH a bit off guard and CMS will need to work with the state over time as they develop a deeper understanding and capacity to meet MCO requirements for KCC. The final issue is one of scale. Policy makers and officials at both CMS and WDH should question the overall viability of the current MCO approach for CHIP. The requirements imposed by statute for CHIP are extensive in consideration of the size of the contract with BCBSWY and the resources available to fulfill them. With that said, one avenue of consideration that Wyoming and CMS may wish to undertake is to consider whether a managed care design would provide Wyoming and those served by Medicaid an advantage if it were extended across the entire system. If not, it may be worth considering whether the one-off for CHIP expansion is worthwhile in a stand-alone MCO system outside of the regular programmatic purview and operation of WDH.

APPENDICES

Appendix A: Terms, Abbreviations and Acronyms

Appendix B: Onsite Interview Participants and Agenda

Appendix C: Scoring of EQR Protocols 1-3

Appendix D: List of Periodic Reports to WDH from BCBSWY

Appendix E: ISCA

Appendix F: PIP reports as submitted to WDH

Appendix A: Terms

Abbreviations and Acronyms

1115 Waiver: Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid requirements. States may apply for a 1115 waiver for increased flexibility in how they use federal Medicaid funds to serve their Medicaid populations.

1915 Waiver: Section 1915(c) of the Social Security Act authorized the Medicaid Home- and Community-Based Services (HCBS) waiver program. Through these waivers, states provide services to individuals in their homes and communities that they would traditionally receive in an institutional setting.

ADHD Medication: A variety of medications used to treat attention deficit hyperactivity disorder (ADHD). The medications typically target an individual's brain chemistry to improve their ability to slow down and concentrate on tasks.

Affordable Care Act (ACA Section 1557): Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.

ADA: The Americans with Disabilities Act, a federal law that prohibits discrimination against individuals with a disability and guarantees access to all areas of public life.

Any Willing Provider State: State laws that prohibits insurance companies from limiting their provider networks. As long as a provider meets conditions set by the health insurance company they must be allowed to become a member of the insurance companies network.

BMI: Body Mass Index

Bridger Solution with Lexus Nexus: Compliance platform that helps organization standardize **compliance processes.**

Case Management: An integrated system used to coordinate the delivery of care in a comprehensive manner for patients.

CHIPRA: The Children's Health Insurance Program Reauthorization Act of 2009, a federal law that reauthorized and expanded states options for covering children under Medicaid and the Children's Health Insurance Program (CHIP).

Clinical Performance Improvement: A process used by healthcare organizations to implement systematic changes to improve performance. Often this involves collecting practice level data on processes and outcomes to identify areas for improvement.

CFR: Code of Federal Regulations

CPT: Current Procedures Terminology is a set of standardized codes and terminology developed by the American Medical Association to report healthcare procedures and services.

EQR Appendix A Terms, Abbreviations and Acronyms

CMS Deemed Managed Care Program: A healthcare organization that serves Medicaid or Medicare individuals on a risk-based contract through employed or affiliated providers.

Delta Dental: A Wyoming based dental insurance company.

EPSDT: Early Periodic Screening and Diagnostic Testing is a comprehensive health check that focuses on preventative measures. EPSDT requires Medicaid programs to provide all medically necessary diagnostic and treatment services (included in federal Medicaid rules) that are identified during the screening regardless of what the state's Medicaid program typically covers.

EQR: External Quality Review

EQRO: External Quality Review Organization

FPL: Federal Poverty Limit

FQHC: Federally Qualified Health Centers are designated health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement.

Fee for Service Medicaid program: A Medicaid payment model where services are paid for separately on a non-capitated basis.

Flesch-Kincaid Grade Level: Scoring system that assigns a grade level to a piece of text to indicate its average readability level.

Full Risk Capitation: A payment model where a provider or health organization receive a fixed amount to provide services to a patient or group or patients for a set period of time. The provider assumes the risk to treat each patient regardless of the amount of care the patient seeks.

Geo Mapping: The process of turning location data into a mapped visualization.

HIPPA: Health Insurance Portability and Accountability Act

HRA: Health Risk Assessment

HEDIS: The Healthcare Effectiveness Data and Information Set

HMHS: HM Health Solutions is a subsidiary of Highmark Inc., which operates Blue Cross Blue Shield insurance plans in several states including Pennsylvania, West Virginia, and Delaware.

ISCA: Information Systems Capability Assessment

MCO: Managed Care Organization

McKesson InterQual: A utilization management criteria framework that helps make evidence-based decisions to assure consistent and appropriate levels of care for patients.

MFCU: Medicaid Fraud Control Unit

Medical Case Management: A treatment plan process where recommended treatment plans are created to help assure patients receive appropriate medical care.

EQR Appendix A Terms, Abbreviations and Acronyms

MMIS/WINGS Enterprise: A project to transition from the current Wyoming Medicaid Management Information System (MMIS) to the next generation Wyoming Integrated Next Generation System (WINGS).

Non-Waivered Populations: Medicaid populations not served under a 1915(c) waiver.

OIG: Office of Inspector General

OSCAR: On-Site Compliance Review

PIP: Performance Improvement Project

PBM: Pharmacy Benefits Manager

Population Health: A healthcare approach aimed at improving the health of a group of individuals rather than a single individual.

PAHP: Prepaid Ambulatory Health Plans

PIHP: Prepaid Inpatient Health Plans

PCCM: Primary Care Case Management

PCP: Primary Care Provider

Protocol 1: EQR protocol used to verify if a Medicaid/CHIP MCO's compliance with Federal quality standards as mandated by the Balanced Budget Act of 1997.

Protocol 2: EQR protocol used to validate a Medicaid/CHIP MCO's Medicaid and CHIP performance measures.

Protocol 3: EQR protocol used to assess the validity and reliability of quality performance improvement projects (PIP) operated by a Medicaid/CHIP MCO.

QMAC: Quality Monitoring and Assurance Committee

Risk Management: A process to identify and analyze potential risk and implement steps to reduce those risks.

SCHIP: State Children's Health Insurance Program

SQL: Structured Query Language is a standard programming language for database management systems.

SPA: State Plan Amendment

SOW: Statement of Work

T-MSIS: The Transformed Medicaid Statistical Information System is a data and systems component of the CMS Medicaid and CHIP Business Information Solution.

URAC Accreditation: A comprehensive accreditation process focused on healthcare quality performed by the non-profit organization URAC.

Utilization Management Team: A team that works to manage healthcare costs through the assessment of the appropriateness of patient care plans.

EQR Appendix A Terms, Abbreviations and Acronyms

WY DHCF: Wyoming's Division of Healthcare Financing

Appendix B: Onsite Interview Participants and Agenda

Wyoming Kid Care CHIP
External Quality Review Onsite Agenda

Meeting: External Quality Review Onsite Meetings
Date: February 20th and 21st, 2019
Location: Blue Cross Blue Shield, 4000 House Ave, Cheyenne, WY

Wednesday, February 20th							
Protocols 1 & 3				Protocol 2			
Time	Meeting	Location	Attendees	Time	Meeting	Location	Attendees
7:30 – 8:00 am	Introductions (Joint meeting between Protocols 1 and 2)	BCBSWY West Conference Room	Maria Montanaro, Navigant, Director Jason Duhon, Navigant, Associate Director Beth Hataway, Navigant, Senior Consultant Diane Gore, EVP, COO Wendy Curran, VP Care Delivery & Provider Affairs Rocky Redd, Director, Legal Affairs/CISO/Compliance Officer Joseph Horam, MD, Medical Director/CMO Kenna Rotert, Governmental Programs	7:30 – 8:00 am	Introductions (Joint meeting between Protocols 1 and 2)	BCBSWY West Conference Room	
8:00 – 11:00 am	Interview: MCO Leadership	BCBSWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Diane Gore, EVP, COO Wendy Curran, VP Care Delivery & Provider Affairs Rocky Redd, Director, Legal Affairs/CISO/Compliance Officer Joseph Horam, MD, Medical Director/CMO Kenna Rotert, Governmental Programs	8:30 – 12:00 pm	Interview: Information Systems	BCBSWY East Conference Room	Jason Duhon, Navigant, Associate Director Michael Wells, VP & CIO Carla Schmid, Sr. Data Architect Matt Odell, Assistant Director, IT Infrastructure & Enterprise Information
11:00 – 11:30 am	Lunch/ Navigant Internal Meeting		Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant				
11:30 – 1:00 pm	Interview: Quality	BCBWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Wendy Curran, VP Care Delivery & Provider Affairs	12:00 – 12:30 pm	Lunch/ Navigant Internal Meeting		Jason Duhon, Navigant, Associate Director

EQR Appendix B Onsite Interview Participants and Agenda

Wednesday, February 20th							
Protocols 1 & 3				Protocol 2			
Time	Meeting	Location	Attendees	Time	Meeting	Location	Attendees
			Joseph Horam, MD, Medical Director/CMO Renee Dilly, VP Internal Operations Amy McKee, Manager Medical Review Kenna Rotert, Governmental Programs				
1:00 – 2:30 pm	Interview: Utilization Management	BCBSWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Joseph Horam, MD, Medical Director/CMO Renee Dilly, VP Internal Operations Amy McKee, Manager Medical Review Kenna Rotert, Governmental Programs	1:00 – 2:00pm 2:00-4:30 pm	Demonstration: Information Systems Claims Performance Measures	BCBWY East Conference Room	Jason Duhon, Navigant, Associate Director Sherry Fierro, Sr. Manager, Claims Michelle Tafoya, Assistant Manager, Claims Carla Schmid, Sr. Data Architect
2:30 – 4:00 pm	Interview: Care Coordination	West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Wendy Curran, VP Care Delivery & Provider Affairs Joseph Horam, MD, Medical Director/CMO Renee Dilly, VP Internal Operations Amy McKee, Manager Medical Review Kenna Rotert, Governmental Programs				
4:00 – 5:00 pm	Interview: Medicaid Director	BSBSWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Christine Bates, State of Wyoming, Kid Care CHIP Manager Jan Stall, State of Wyoming, Client Services Administrator				

EQR Appendix B Onsite Interview Participants and Agenda

Thursday, February 21st							
Protocol 1				Protocol 2			
Time	Meeting	Location	Attendees	Time	Meeting	Location	Attendees
8:00 – 9:00 am	Follow-up discussion (Joint meeting between Protocols 1 and 2)	BCBSWY West Conference Room	Maria Montanaro, Navigant, Director Jason Duhon, Navigant, Associate Director Beth Hataway, Navigant, Senior Consultant Kenna Rotert, Governmental Programs	8:00 – 9:00 am	Follow-up discussion (Joint meeting between Protocols 1 and 2)	BCBSWY West Conference Room	:
9:00 – 11:00 am	Interview: Provider/ Contractor Services	BCBWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Wendy Curran, VP Care Delivery & Provider Affairs Jenny Lakin, Supervisor, Provider Relations	9:00 – 11:00 am	Demonstration: Information Systems	BCBSWY East Conference Room	Jason Duhon, Navigant, Associate Director
11:00 – 1:00 pm	Interview: Enrollee Services	BCBSWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Wendy Curran, VP Care Delivery & Provider Affairs Kristin Bernatow, Manager, Planning & Implementation Logan Trautwein, Manager, Member Services Michelle Boltz, Assistant Manager, Member Services Doug Schultz, Manager, Market Services Kenna Rotert, Governmental Programs	11:00 – 12:00 pm	Interview: Information Systems	BCBSWY East Conference Room	Jason Duhon, Navigant, Associate Director Michael Wells, VP & CIO Carla Schmid, Sr. Data Architect Matt Odell, Assistant Director, IT Infrastructure & Enterprise Information
				12:00 – 12:30 pm	Lunch/ Navigant Internal Meeting		Jason Duhon, Navigant, Associate Director
1:00 – 2:00 pm	Interview: Delta Dental	BCBWY West Conference Room	Maria Montanaro, Navigant, Director Beth Hataway, Navigant, Senior Consultant Kerry Hall, President, Delta Dental Patti Guzman, VP, Delta Dental Jenny Hanrahan, Delta Dental, Director of Accounting	1:00 – 2:00 pm	Demonstration: Information Systems Member Data		Jason Duhon, Navigant, Associate Director Kristin Bernatow, Manager, Planning & Implementation Bridgett Garcia, Supervisor, Enrollment Amber Zowada (tentative), Director of Internal Operations
2:00 – 3:00 pm	Navigant Internal Meeting (Joint meeting between		Maria Montanaro, Navigant, Director Jason Duhon, Navigant, Associate Director Beth Hataway, Navigant, Senior Consultant	2:00 – 3:00 pm	Navigant Internal Meeting (Joint meeting between Protocols 1 and 2)		

EQR Appendix B Onsite Interview Participants and Agenda

Thursday, February 21st							
Protocol 1				Protocol 2			
Time	Meeting	Location	Attendees	Time	Meeting	Location	Attendees
	Protocols 1 and 2)						
3:00 – 4:00 pm	Follow-up/ Close Out (Joint meeting between Protocols 1 and 2)	BCBSWY Board Room	Maria Montanaro, Navigant, Director Jason Duhon, Navigant, Associate Director Beth Hataway, Navigant, Senior Consultant Diane Gore, EVP, COO Wendy Curran, VP Care Delivery & Provider Affairs Rocky Redd, Director, Legal Affairs/CISO/Compliance Officer Joseph Horam, MD, Medical Director/CMO Michael Wells, VP & CIO Renee Dilly, VP Internal Operations Kenna Rotert, Governmental Programs Christine Bates, State of Wyoming, Kid Care CHIP Manager Jan Stall, State of Wyoming, Client Services Administrator	3:00 – 4:00 pm	Follow-up/ Close Out (Joint meeting between Protocols 1 and 2)	BCBSWY Board Room	

Information Technology Review Sessions

Attendees:

Navigant: Jason Duhon, Associate Director
BCBS:

Demonstrations Required:

1. Navigant will observe BCBS generate the following performance measures.
    a. Pull at least one claim included in the numerator for each measure to make sure the data on the claim matches (e.g., on the paper HCFA 1500 form or the 837P) the data in the DSS.
    b. Pull at least one claim excluded from denominator for each measure to make sure the data on the claim matches the data in the DSS
    c. Review at least one member included and excluded for the measure. For example, we want to understand the member has met the continuous enrollment requirement (if required) and that the age is calculated correctly (if required) and the appropriate gender is included (if required). Also, what processes exist to ensure the member is not counted twice.
    d. Discuss any manual processes the update the measure from the automatic calculation
    e. Discuss any non-standard codes used in calculating the measure
    f. Discuss how the plan confirms the accuracy of the numerator, denominator, and calculation (e.g., do they compare it to the previous year, perform sampling of the

numerator/denominator, perform statistical testing of results, or other processes?)
   g. Review documentation and programming (if necessary) for creating the measure
   h. Review production runs and run control information

2. Observe claims correction staff
   a. Observe someone work an individual claim. For example, if someone is performing a 'data correct' process after the paper claims are OCR'ed or working a suspended claim—this is what we'd like to observe
3. Discuss FFS claims and encounter claims processing (including claims processing subcontracted out to other plans)
   a. How does the plan process and pay FFS claims—how do they ensure all claims received are processed?
   b. How does the plan ensure that encounter data is submitted timely, completely and accurately?
4. Discuss provider data
   a. How does the plan keep provider data in sync with the state?
   b. How often does the plan receive a provider file from the state, and how is it processed (i.e., what do they use of it to update their system)
5. Discuss member data
   a. How does the plan keep member data up-to-date
6. System controls in the place—review the processes used to input, confirm entry, and identify errors and well as those used to transmit and track the data through systems
   a. Any other controls for backups, recovery, archiving, or other control functions
7. Decision Support System
   a. Discuss the process flow of data from system entry to being stored in the DSS/BI/Repository
   b. Review data and query processes implemented in the DSS—again, we'd like to see the performance measure being run

Appendix C: Navigant's scoring for EQR Protocols 1-3

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
The language(s) that the State has determined are prevalent in the MCO's geographic service area.	3. Partially Met
Any requirements the State has issued to the MCO specifying a standard for the reading level of written materials prepared for enrollees. BCBS contract specifies that the enrollee handbook must be 8th grade reading level.	4. Minimally Met
The State's decision about whether or not the MCO is to notify all enrollees at least once a year their rights to request and obtain the information listed in paragraphs (f)(6) and (g) of §438.10.	5. Not Met
The State's decision about whether the MCO is to furnish to each of its Medicaid/CHIP enrollees the information listed in paragraphs (f)(6) and (g) within a reasonable time after the MCO receives, from the State or its contracted representative, notice of the recipient's enrollment.	3. Partially Met
Information on how the State has defined a "significant change" in the information MCOs are required to give enrollees pursuant to §438.10(f) and (g)	3. Partially Met
Whether or not the MCO is part of a State managed care initiative that employs mandatory enrollment of beneficiaries in the MCO under section 1932(a)(1)(A) of the Act. If the MCO is part of such an initiative, obtain information from the State on the State's decision about whether the State or the MCO is to provide potential enrollees with the information contained in §438.10(h).	N/A
If the MCO is part of a mandatory managed care initiative AND IF the State has directed the MCO to provide comparative information on disenrollment as part of a chart-like comparison of MCOs obtain the State agency's definition of "disenrollment rate".	N/A
Whether or not the State agency has chosen to give providers the right to challenge the failure of an MCO to cover a contracted service.	2. Substantially Met
Any applicable State laws on enrollee rights.	1. Fully Met

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
Information on whether or not the MCO has documented to the State any moral or religious objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a particular Medicaid/CHIP service or services.	5. Not Met
A written description of any State law(s) concerning advance directives. The written description may include information from State statutes on advance directives, regulations that implement the statutory provisions, opinions rendered by State courts and other States administrative directives. [Note to reviewers: Each State Medicaid/CHIP agency is required under Federal regulations at 42 CFR 431.20 to develop such a description of State laws and to distribute it to all MCOs. Revisions to this description as a result of changes in State law are to be sent to MCOs no later than 60 days from the effective date of the change in State law.]	5. Not Met
Information on whether or not the MCO has documented to the State any moral or religious objection to fulfilling the regulatory provisions pertaining to advance directives	5. Not Met
Obtain from the State Medicaid/CHIP agency the identification of all State laws that pertain to enrollee rights and with which the State Medicaid/CHIP Agency requires its MCOs to comply.	1. Fully Met
Information on whether or not: The State agency has required the MCO to adhere to any explicit standards for provider network adequacy, such as prescribed primary physician/enrollee ratios or specialist/enrollee ratios	2. Substantially Met
The State agency has in place any time or distance standards for beneficiary travel to access covered services in Medicaid/CHIP fee-for service	3. Partially Met
There are any State laws requiring MCOs to make specific types of providers available for the provision of certain services	3. Partially Met
Obtain a copy of the State Medicaid/CHIP agency's standards for timely enrollee access to care and services required of Medicaid/CHIP and MCOs.	3. Partially Met
Descriptive information on the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	4. Minimally Met

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
The requirements the State has communicated to the MCO with respect to how the MCO is expected to participate in the State's efforts to promote the delivery of services in a culturally competent manner.	4. Minimally Met
*Definition/specifications used by State to identify individuals with special health care needs (SHCNs).[14]	5. Not Met
*Methods used by the State to identify to the MCO new enrollees with SHCNs.	5. Not Met
*Whether the MCO is required to screen to identify and/or assess persons with SHCNs using the State's definition of SHCNs.	5. Not Met
State requirements for MCO care coordination programs.	4. Minimally Met
If the organization to be reviewed is a MCO, whether the MCO is required to ensure each enrollee has: A) an ongoing source of primary care appropriate to his/her needs, and B) a person/entity formally and primarily responsible for coordinating the health care services furnished to the enrollee.	5. Not Met
If the organization is an MCO serving enrollees also enrolled in a Medicare Advantage plan and receiving Medicare benefits, information about the extent to which the MCO is required to implement: - for enrollees determined to have ongoing special conditions that require a course of treatment or regular care monitoring, a mechanism to ensure that: (1) the enrollee may directly access a specialist (e.g., through a standing referral or approved number of visits) as appropriate for the enrollee's condition and identified needs; and (2) a treatment plan that, if required by the MCO is developed by the specialist in consultation with the enrollee's primary care provider, and is (i) developed with enrollee participation; (ii) approved by the MCO in a timely manner, if this approval is required; and (iii) In accord with the State's quality assurance and utilization review standards. - a primary care and coordination program that meets State requirements and ensures each enrollee has: 1) an ongoing source of primary care appropriate to his/her needs; and 2) a person or entity formally and primarily responsible for coordinating health	N/A

[14] Children with special health care needs (SHCNs) would typically qualify for a wider range of services that are not covered by the KCC program.

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
care services furnished to the enrollee.	
The State's quality assurance and utilization review standards.	4. Minimally Met
Obtain from the State Medicaid/CHIP agency the State-established standards for MCO processing of standard authorization decisions.	4. Minimally Met
Obtain from the State Medicaid/CHIP agency the State-established standards for MCO processing of standard authorization decisions.	4. Minimally Met
Obtain from the State information on any credentialing, recredentialing, or other provider selection and retention requirements established by the State.	1. Fully Met
Information on: Whether or not the State Medicaid/CHIP agency allows the MCO to process enrollee requests for disenrollment for cause and, if so, whether or not the State requires enrollees to seek redress through the MCO's grievance system before the State makes a determination on the enrollee's request.	N/A
A copy of the State-MCO contract provisions, which specify the methods by which the MCO assures the State Medicaid/CHIP agency that it does not request disenrollment for reasons other than those permitted under the contract.	N/A
Obtain information on whether or not the State delegates responsibility to the MCO for providing each Medicaid/CHIP enrollee (who has received an adverse decision with respect to a request for a covered service) notice that he or she has the right to a State fair hearing to reconsider their request for the covered service	4. Minimally Met
Obtain from the State the "periodic schedule" established by the State according to which the MCO is to monitor and formally review on an ongoing basis all subcontractors' performance of any delegated activities	1. Fully Met
Obtain from the State Medicaid/CHIP agency: Information on whether or not the State Medicaid/CHIP agency has required the MCO's performance improvement projects to address a specific topic(s), or address a specific topic(s) and also use specific quality indicators identified by the State Medicaid/CHIP agency	3. Partially Met
The State's requirements with respect to MCO reporting of the status and results of	1. Fully Met

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
each performance improvement project to the State Medicaid/CHIP agency	
Any reports on the status and results of the performance improvement projects submitted by the MCO in response to State requirements for reporting the status and results of each performance improvement project to the State Medicaid/CHIP agency	1. Fully Met
Obtain from the State Medicaid/CHIP agency:1) A list of all performance measures required of the MCO by the State for the year or years for which the review is being conducted	2. Substantially Met
The actual performance measures submitted by the MCO to the State for the year or years for which the review is being conducted	2. Substantially Met
Instructions from the State on whether or not the State wishes the EQRO to validate the MCO's submitted performance measures.	1. Fully Met
Determine from the State Medicaid/CHIP agency whether or not the State has required the MCO to have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement (QAPI) program and, if so, how frequently the MCO is to make such an evaluation.	5. Not Met
Information on whether or not the State has required the MCO to undergo, or has otherwise received, a recent assessment of the MCO's health information system. If the State has required or received such an assessment, obtain a copy of the information system Assessment from the State or the MCO. Also obtain contact information about the person or entity that conducted the assessment and to whom follow-up questions may be addressed.	1. Fully Met
State specifications for data on enrollee and provider characteristics that must be collected by the MCO.	N/A
State specifications for how MCOs are to collect data on services furnished to enrollees (i.e., whether or not the MCO must collect encounter data or may use other methods). If the State allows the MCO to use other methods, what are the State's requirements with respect to these "other methods?" If the State requires MCOs to collect encounter data and report it to the State, does the State validate this data or require it to be validated? If the data is validated, obtain a copy of the most recent validation report.	5. Fully Met

EQR Appendix C Scoring of EQR Protocols 1-3

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
Obtain from the State information on: The time frame during which enrollees and providers are allowed to file an appeal	1. Fully Met
Whether or not the State requires enrollees to exhaust MCO level appeals prior to requesting a State fair hearing; and	1. Fully Met
Whether enrollees are required or permitted to file a grievance with either the State or the MCO or both.	3. Partially Met
Obtain from the State Medicaid/CHIP Agency information on the time frames within which it requires MCOs to make standard (initial) coverage and authorization decisions and provide written notice to requesting enrollees. These time frames will be the required period within which MCOs must provide Medicaid/CHIP enrollees written notice of any intent to deny or limit a service (for which previous authorization has not been given by the MCO) and the enrollee's right to file an MCO appeal (or request a State fair hearing if the State does not require the enrollee to exhaust MCO level appeals prior to requesting a State fair hearing).	4. Minimally Met
Obtain from the State Medicaid/CHIP Agency: The State-established standard time frames during which the State requires MCOs to: - dispose of a grievance and notify the affected parties of the result; - resolve appeals and notify affected parties of the decision; and - expedite and resolve appeals and notify affected parties of the decision.	2. Substantially Met
The methods prescribed by the State that the MCO must follow to notify an enrollee of the disposition of a grievance.	1. Fully Met
Information on whether or not the State requires Medicaid/CHIP enrollees to exhaust MCO level appeals before receiving a State fair hearing	1. Fully Met
Obtain from the State Medicaid/CHIP Agency information on: Whether the State develops or approves the MCO's description of its grievance system that the MCO is required to provide to all Medicaid/CHIP enrollees [Note that under regulations at §438.10(g)(1) the State must either develop a description for use by the MCO or approve a description developed by the MCO]	1. Fully Met
If the States approves, rather than develops, the description of the MCO's grievance system, information on whether or not the State has already approved the MCO's description	1. Fully Met

EQR Appendix C Scoring of EQR Protocols 1-3

EQR Protocol 1: Compliance with MCO Regulations

Requirement	Score
The State-specified time frames for disposition of grievances	1. Fully Met
Obtain from the State Medicaid/CHIP Agency information on any time limits specified by the State that must be met by Medicaid/CHIP enrollees who wish to file an appeal, request for expedited appeal, or State fair hearing	2. Substantially Met
Obtain from the State Medicaid/CHIP Agency information on whether the State or the MCO is required to pay for services in situation in which the MCO, or the State fair hearing officer reversed a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending	1. Fully Met

EQR Protocol 2: Validation of Measures

Requirement	Score
Accuracy of data transfers to assigned performance measure repository	
MCO processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated	1. Fully Met
Samples of data from repository are complete and accurate	1. Fully Met
Accuracy of file consolidations, extracts, and derivations	
MCO's processes to consolidate diversified files and to extract required information from the performance measure repository are appropriate	5. Not Met
Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	N/A
Procedures for coordinating the activities of vendors ensure the accurate, timely, and complete integration of data into the performance measure database	5. Not Met
Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer	4. Minimally Met
If the MCO uses one, the structure and format of the performance measure data repository facilitates any required programming necessary to calculate and report required performance measures.	
The repository's design, program flow charts, and source codes enable analyses and reports	4. Minimally Met
Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition)	2. Substantially Met
Assurance of effective management of report production and of the reporting software.	
Documentation governing the production process, including MCO production activity logs, and MCO staff review of report runs was adequate	5. Not Met
Prescribed data cutoff dates were followed	5. Not Met
The MCO has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced	1. Fully Met
Reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production	5. Not Met

EQR Appendix C Scoring of EQR Protocols 1-3

EQR Protocol 2: Validation of Measures

Requirement	Score
MCO's processes and documentation comply with the MCO standards associated with reporting program specifications, code review, and testing	5. Not Met

EQR Protocol 2: Validation of Measures

ADD – ADHD Performance Measure	
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	
All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	1. Fully Met
Adequate programming logic or source code exists to appropriately identify all "relevant" members of the specified denominator population for each of the performance measures	
For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product line (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	1. Fully Met
Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	5. Not Met
Proper mathematical operations were used to determine patient age or range.	1. Fully Met
The MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO can explain what classification is carried out if neither of the required codes is present.	N/A
The MCO has correctly calculated member months and member years, if applicable to the performance measure.	1. Fully Met
Completeness and accuracy of the codes used to identify medical events has been identified and the codes have been appropriately applied.	
The MCO has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	4. Minimally Met
Specified time parameters are followed.	

Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	1. Fully Met
Exclusion criteria included in the performance measure specifications have been followed.	
Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	5. Not Met
Systems to estimate populations, which cannot be accurately counted, exist and are utilized when appropriate.	
Systems or methods used by the MCO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	N/A
All appropriate data are used to identify the entire at-risk population.	
The MCO has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	1. Fully Met
The MCO has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO.	5. Not Met
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services	
The MCO's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when	4. Minimally Met
The MCO correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	4. Minimally Met
The MCO has avoided or eliminated all double-counted members or numerator events	5. Not Met
Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	5. Not Met
Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	1. Fully Met

AMB – Ambulatory Care ER Visits Performance Measure	
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	
All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2. Substantially Met
Adequate programming logic or source code exists to appropriately identify all "relevant" members of the specified denominator population for each of the performance measures	
For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product line (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	1. Fully Met
Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	5. Not Met
Proper mathematical operations were used to determine patient age or range.	1. Fully Met
The MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO can explain what classification is carried out if neither of the required codes is present.	N/A
The MCO has correctly calculated member months and member years, if applicable to the performance measure.	4. Minimally Met
Completeness and accuracy of the codes used to identify medical events has been identified and the codes have been appropriately applied.	
The MCO has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	5. Not Met
Specified time parameters are followed.	
Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	4. Minimally Met

Exclusion criteria included in the performance measure specifications have been followed.	
Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	5. Not Met
Systems to estimate populations, which cannot be accurately counted, exist and are utilized when appropriate.	
Systems or methods used by the MCO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	N/A
All appropriate data are used to identify the entire at-risk population.	
The MCO has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	4. Minimally Met
The MCO has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO.	5. Not Met
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services	
The MCO's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when	5. Not Met
The MCO correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	5. Not Met
The MCO has avoided or eliminated all double-counted members or numerator events	5. Not Met
Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	5. Not Met
Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	4. Minimally Met

AMR – Asthma Med Ratio Performance Measure	
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	
All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2. Substantially Met
Adequate programming logic or source code exists to appropriately identify all "relevant" members of the specified denominator population for each of the performance measures	
For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product line (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	1. Fully Met
Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	1. Fully Met
Proper mathematical operations were used to determine patient age or range.	1. Fully Met
The MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO can explain what classification is carried out if neither of the required codes is present.	N/A
The MCO has correctly calculated member months and member years, if applicable to the performance measure.	4. Minimally Met
Completeness and accuracy of the codes used to identify medical events has been identified and the codes have been appropriately applied.	
The MCO has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	5. Not Met
Specified time parameters are followed.	
Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	4. Minimally Met
Exclusion criteria included in the performance measure specifications have been followed.	

Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	5. Not Met
Systems to estimate populations, which cannot be accurately counted, exist and are utilized when appropriate.	
Systems or methods used by the MCO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	N/A
All appropriate data are used to identify the entire at-risk population.	
The MCO has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	4. Minimally Met
The MCO has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO.	5. Not Met
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services	
The MCO's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when	5. Not Met
The MCO correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	1. Fully Met
The MCO has avoided or eliminated all double-counted members or numerator events	5. Not Met
Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	1. Fully Met
Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	1. Fully Met

CHL – Chlamydia Screen Age 16 – 20 Performance Measure	
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	
All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	5. Not Met
Adequate programming logic or source code exists to appropriately identify all "relevant" members of the specified denominator population for each of the performance measures	
For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product line (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	1. Fully Met
Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	1. Fully Met
Proper mathematical operations were used to determine patient age or range.	1. Fully Met
The MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO can explain what classification is carried out if neither of the required codes is present.	N/A
The MCO has correctly calculated member months and member years, if applicable to the performance measure.	4. Minimally Met
Completeness and accuracy of the codes used to identify medical events has been identified and the codes have been appropriately applied.	
The MCO has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	5. Not Met
Specified time parameters are followed.	
Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	1. Fully Met
Exclusion criteria included in the performance measure specifications have been followed.	

Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	5. Not Met
Systems to estimate populations, which cannot be accurately counted, exist and are utilized when appropriate.	
Systems or methods used by the MCO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	N/A
All appropriate data are used to identify the entire at-risk population.	
The MCO has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	4. Minimally Met
The MCO has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO.	5. Not Met
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services	
The MCO's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when	5. Not Met
The MCO correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	5. Not Met
The MCO has avoided or eliminated all double-counted members or numerator events	1. Fully Met
Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	5. Not Met
Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	1. Fully Met

DEV – CH – DEV Screen 1st 3 Years Performance Measure	
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	
All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2. Substantially Met
Adequate programming logic or source code exists to appropriately identify all "relevant" members of the specified denominator population for each of the performance measures	
For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product line (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	1. Fully Met
Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	1. Fully Met
Proper mathematical operations were used to determine patient age or range.	1. Fully Met
The MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO can explain what classification is carried out if neither of the required codes is present.	N/A
The MCO has correctly calculated member months and member years, if applicable to the performance measure.	4. Minimally Met
Completeness and accuracy of the codes used to identify medical events has been identified and the codes have been appropriately applied.	
The MCO has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	5. Not Met
Specified time parameters are followed.	
Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	1. Fully Met
Exclusion criteria included in the performance measure specifications have been followed.	

Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	5. Not Met
Systems to estimate populations, which cannot be accurately counted, exist and are utilized when appropriate.	
Systems or methods used by the MCO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	N/A
All appropriate data are used to identify the entire at-risk population.	
The MCO has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	3. Partially Met
The MCO has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO.	3. Partially Met
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services	
The MCO's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when	5. Not Met
The MCO correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	1. Fully Met
The MCO has avoided or eliminated all double-counted members or numerator events	1. Fully Met
Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	1. Fully Met
Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	1. Fully Met

FUH – MI Hosp Follow-Up Performance Measure	
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	
All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	1. Fully Met
Adequate programming logic or source code exists to appropriately identify all "relevant" members of the specified denominator population for each of the performance measures	
For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product line (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	1. Fully Met
Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	5. Not Met
Proper mathematical operations were used to determine patient age or range.	1. Fully Met
The MCO can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCO can explain what classification is carried out if neither of the required codes is present.	N/A
The MCO has correctly calculated member months and member years, if applicable to the performance measure.	1. Fully Met
Completeness and accuracy of the codes used to identify medical events has been identified and the codes have been appropriately applied.	
The MCO has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	5. Not Met
Specified time parameters are followed.	
Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	1. Fully Met
Exclusion criteria included in the performance measure specifications have been followed.	

Performance measure specifications or definitions that exclude members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	5. Not Met
Systems to estimate populations, which cannot be accurately counted, exist and are utilized when appropriate.	
Systems or methods used by the MCO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	N/A
All appropriate data are used to identify the entire at-risk population.	
The MCO has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	3. Partially Met
The MCO has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCO.	5. Not Met
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services	
The MCO's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when	5. Not Met
The MCO correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator	5. Not Met
The MCO has avoided or eliminated all double-counted members or numerator events	5. Not Met
Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	5. Not Met
Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure)	4. Minimally Met

EQR Protocol 3: Validating Performance Improvement Projects (PIPs)

PIPs #1: Increase the number of Kid Care children who have received a well-child visit or age aligned Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening.	
Component/Standard	**Review Status**
Step 1: Review the Selected Study Topic(s)	
Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	1. Yes
Is the PIP consistent with the demographics and epidemiology of the enrollees?	1. Yes
Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	2. No
Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	1. Yes
Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	1. Yes
Step 2: Review the Study Question(s)	
Was/were the study question(s) measurable and stated clearly in writing?	1. Yes
Step 3: Review the Identified Study Populations	
Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	1. Yes
Did the indicators track performance over a specified period of time?	1. Yes
Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	1. Yes
Step 4: Review Selected Study Indicator(s)	
Were the enrollees to whom the study question and indicators are relevant clearly defined?	1. Yes
If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	1. Yes
Step 5: Review Sampling Methods	
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	3. N/A

EQR Protocol 3: Validating Performance Improvement Projects (PIPs)

PIPs #1: Increase the number of Kid Care children who have received a well-child visit or age aligned Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening.	
Component/Standard	**Review Status**
Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	3. N/A
Did the sample contain a sufficient number of enrollees?	3. N/A
Step 6: Review Data Collection Procedures	
Did the study design clearly specify the data to be collected?	1. Yes
Did the study design clearly specify the sources of data?	1. Yes
Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	1. Yes
Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	1. Yes
Did the study design prospectively specify a data analysis plan?	1. Yes
Were qualified staff and personnel used to collect the data?	1. Yes
Step 7: Review Data Analysis and Interpretation of Study Results	
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	2. No
Are the interventions sufficient to be expected to improve processes or outcomes?	2. No
Are the interventions culturally and linguistically appropriate?	3. N/A
Step 8: Assess Improvement Strategies	
Was an analysis of the findings performed according to the data analysis plan?	2. No
Were numerical PIP results and findings accurately and clearly presented?	1. Yes
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?	2. No
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	1. Yes
Step 9: Assess Whether Improvement is "Real" Improvement	
Was the same methodology as the baseline measurement used when measurement was repeated?	1. Yes

EQR Protocol 3: Validating Performance Improvement Projects (PIPs)

PIPs #1: Increase the number of Kid Care children who have received a well-child visit or age aligned Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening.	
Component/Standard	**Review Status**
Was there any documented, quantitative improvement in processes or outcomes of care?	2. No
Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	3. N/A
Is there any statistical evidence that any observed performance improvement is true improvement?	3. N/A
Step 10: Assess Sustained Improvement	
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	3. N/A

PIPs #2: Reduce the number of Kid Care children who have a diagnosis of obesity and uncontrolled diabetes in order to improve health status.	
Component/Standard	**Review Status**
Step 1: Review the Selected Study Topic(s)	
Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	1. Yes
Is the PIP consistent with the demographics and epidemiology of the enrollees?	1. Yes
Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	2. No
Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	2. No
Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	2. No
Step 2: Review the Study Question(s)	
Was/were the study question(s) measurable and stated clearly in writing?	2. No
Step 3: Review the Identified Study Populations	

PIPs #2: Reduce the number of Kid Care children who have a diagnosis of obesity and uncontrolled diabetes in order to improve health status.	
Component/Standard	**Review Status**
Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	2. No
Did the indicators track performance over a specified period of time?	2. No
Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	2. No
Step 4: Review Selected Study Indicator(s)	
Were the enrollees to whom the study question and indicators are relevant clearly defined?	1. Yes
If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	3. N/A
Step 5: Review Sampling Methods	
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	3. N/A
Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	3. N/A
Did the sample contain a sufficient number of enrollees?	3. N/A
Step 6: Review Data Collection Procedures	
Did the study design clearly specify the data to be collected?	1. Yes
Did the study design clearly specify the sources of data?	1. Yes
Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	1. Yes
Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	1. Yes
Did the study design prospectively specify a data analysis plan?	1. Yes
Were qualified staff and personnel used to collect the data?	1. Yes
Step 7: Review Data Analysis and Interpretation of Study Results	

PIPs #2: Reduce the number of Kid Care children who have a diagnosis of obesity and uncontrolled diabetes in order to improve health status.	
Component/Standard	**Review Status**
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	2. No
Are the interventions sufficient to be expected to improve processes or outcomes?	2. No
Are the interventions culturally and linguistically appropriate?	3. N/A
Step 8: Assess Improvement Strategies	
Was an analysis of the findings performed according to the data analysis plan?	1. Yes
Were numerical PIP results and findings accurately and clearly presented?	1. Yes
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?	1. Yes
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	2. No
Step 9: Assess Whether Improvement is "Real" Improvement	
Was the same methodology as the baseline measurement used when measurement was repeated?	1. Yes
Was there any documented, quantitative improvement in processes or outcomes of care?	2. No
Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	3. N/A
Is there any statistical evidence that any observed performance improvement is true improvement?	3. N/A
Step 10: Assess Sustained Improvement	
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	3. N/A

PIPs #3: Increase compliance with annual pediatric dental screenings and EPSDT dental screenings.	
Component/Standard	**Review Status**
Step 1: Review the Selected Study Topic(s)	

PIPs #3: Increase compliance with annual pediatric dental screenings and EPSDT dental screenings.	
Component/Standard	**Review Status**
Was the topic selected through data collection and analysis of comprehensive aspects of specific MCO enrollee needs, care, and services?	1. Yes
Is the PIP consistent with the demographics and epidemiology of the enrollees?	1. Yes
Did the PIP consider input from enrollees with special health needs, especially those with mental health and substance abuse problems?	2. No
Did the PIP, over time, address a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.)?	1. Yes
Did the PIP, over time, include all enrolled populations (i.e., special health care needs)?	3. N/A
Step 2: Review the Study Question(s)	
Was/were the study question(s) measurable and stated clearly in writing?	1. Yes
Step 3: Review the Identified Study Populations	
Did the study use objective, clearly defined, measurable indicators (e.g., an event or status that will be measured)?	1. Yes
Did the indicators track performance over a specified period of time?	1. Yes
Are the number of indicators adequate to answer the study question; appropriate for the level of complexity of applicable medical practice guidelines; and appropriate to the availability of and resources to collect necessary data?	1. Yes
Step 4: Review Selected Study Indicator(s)	
Were the enrollees to whom the study question and indicators are relevant clearly defined?	1. Yes
If the entire population was studied, did its data collection approach capture all enrollees to whom the study question applied?	1. Yes
Step 5: Review Sampling Methods	
Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the acceptable margin of error?	3. N/A
Were valid sampling techniques employed that protected against bias? Specify the type of sampling or census used:	3. N/A
Did the sample contain a sufficient number of enrollees?	3. N/A

PIPs #3: Increase compliance with annual pediatric dental screenings and EPSDT dental screenings.	
Component/Standard	**Review Status**
Step 6: Review Data Collection Procedures	
Did the study design clearly specify the data to be collected?	1. Yes
Did the study design clearly specify the sources of data?	1. Yes
Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply?	1. Yes
Did the instruments for data collection provide for consistent and accurate data collection over the time periods studied?	1. Yes
Did the study design prospectively specify a data analysis plan?	1. Yes
Were qualified staff and personnel used to collect the data?	1. Yes
Step 7: Review Data Analysis and Interpretation of Study Results	
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	1. Yes
Are the interventions sufficient to be expected to improve processes or outcomes?	1. Yes
Are the interventions culturally and linguistically appropriate?	3. N/A
Step 8: Assess Improvement Strategies	
Was an analysis of the findings performed according to the data analysis plan?	1. Yes
Were numerical PIP results and findings accurately and clearly presented?	1. Yes
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?	1. Yes
Did the analysis of study data include an interpretation of the extent to which its PIP was successful and follow-up activities?	2. No
Step 9: Assess Whether Improvement is "Real" Improvement	
Was the same methodology as the baseline measurement used when measurement was repeated?	1. Yes
Was there any documented, quantitative improvement in processes or outcomes of care?	2. No
Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)?	3. N/A

PIPs #3: Increase compliance with annual pediatric dental screenings and EPSDT dental screenings.	
Component/Standard	**Review Status**
Is there any statistical evidence that any observed performance improvement is true improvement?	3. N/A
Step 10: Assess Sustained Improvement	
Was sustained improvement demonstrated through repeated measurements over comparable time periods?	3. N/A

EQR Appendix D- List of Reports Submitted to WDH by BCBSWY

Report Name: Quarterly Reporting Log	Type	From d(De	Due Date Send all quarterlie	Date Jul-18	Date Aug-18	Date Sep-18	Date Oct-18	Date Nov-18	Date Dec-18	Date Jan-19
Quarterly Actuarial Reporting	Management	Actuary	Submitted thirty (30) calendar days after the	Sent 7/30/18	No quarterly reporting due	No quarterly reportin g due	10/31/2018	No quarterly reportin g due	No quarterly reportin g due	
Quarterly Enrollment Count Summary By Age at Latest Date of Coverage During	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Sent 7/9/2018	No quarterly reportin g due	No quarterly reportin g due	10/9/2018	No quarterly reportin g due	No quarterly reportin g due	1/8/2019
Benefit Limitations Fulfilled - Summary	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Received 7/9/18 - Notified Christine	No quarterly reportin g due	No quarterly reportin g due	10/9/2018	No quarterly reportin g due	No quarterly reportin g due	1/8/2019
Benefit Limitations Fulfilled - Detail	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Received 7/9/18 - Notified Christine	No quarterly reportin g due	No quarterly reportin g due	10/9/2018	No quarterly reportin g due	No quarterly reportin g due	1/8/2019
Well Child - Summary	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Sent 7/9/2018	No quarterly reportin g due	No quarterly reportin g due	10/9/2018	No quarterly reportin g due	No quarterly reportin g due	1/14/2019
Well Child - Detail	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Sent 7/9/2018	No quarterly reportin g due	No quarterly reportin g due	10/9/2018	No quarterly reportin g due	No quarterly reportin g due	1/14/2019
FQHC Claims by Clinic	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Sent 7/9/2018	No quarterly reportin g due	No quarterly reportin g due	10/9/2018 Medical 10/25/18 Dental	No quarterly reportin g due	No quarterly reportin g due	1/8/2019
FQHC Claims Detail	Management	Planning and Implementation	Submitted thirty (30) calendar days after the end of	Sent 7/9/2018	No quarterly reportin g due	No quarterly reportin g due	10/9/2018 Medical 10/25/18 Dental	No quarterly reportin g due	No quarterly reportin g due	1/8/2019
Quality Assurance and Monitoring (SLA/SOW 20) - Beginning 9/30/17 and the last day of	Status	Care Delivery and Coordination-Medical Management	Submitted thirty (30) calendar days after the end of	7/31/18Sent	No quarterly reportin g due	No quarterly reportin g due	10/15/2018	No quarterly reportin g due	No quarterly reportin g due	
* % of Children with a Designated Primary Service Provider (SLA 12 SOW 20) (2017 contract reqirement references pending CMS waiver) * Children Receiving EPSDT Services (SLA/SOW	Status		Submitted thirty (30) calendar days after the end of each quarter; quarters are based off the State Fiscal Year	7/31/2018	No quarterly reportin g due	No quarterly reportin g due	10/15/2018	No quarterly reportin g due	No quarterly reportin g due	
Performance Improvement Program Review (SLA/SOW 22) Medical and Dental	Status	Medical Management Amy McKee	Submitted thirty (30) calendar days after the	Sent 7/31/2018	No quarterly reporting due	No quarterly reporting due	10/15/2018 Medical 10/31/18 Dental	No quarterly reporting due	No quarterly reporting due	

EQR Appendix D List of Periodic Reports to WDH from BCBSWY

Grievances and Appeals (SLA/SOW 34&35) Medical and Dental- Quarterly reporting requirement in	Status	Medical Management Amy McKee	Submitted thirty (30) calendar days after the end of each quarter;	Sent 7/31/2018	No quarterly reporting due	No quarterly reporting due	10/31/2018	No quarterly reporting due	No quarterly reporting due	
Provider Adequacy (SLA 9 SOW 22) Medical and Dental	Status	Provider Relations Kris Urbanek	Submitted thirty (30) calendar days after the end of each quarter; quarters are based off the State	Sent 7/31/2018	No quarterly reporting due	No quarterly reporting due	10/15/2018	No quarterly reporting due	No quarterly reporting due	
Physician Report by County	Status	Provider Relations Kris Urbanek		Sent 7/31/2018	No quarterly reporting due	No quarterly reporting due	10/15/2018	No quarterly reporting due	No quarterly reporting due	
Dental - CHC Reporting	Management	Delta Dental		Sent 7/10/18	No quarterly reporting due	No quarterly reporting due	10/9/2018	No quarterly reporting due	No quarterly reporting due	1/7/2019
Dental - Quarterly Experience	Management	Delta Dental		Sent 7/31/2018	No quarterly reporting due	No quarterly reporting due	10/31/2018	No quarterly reporting due	No quarterly reporting due	
Retroactive Cancellations -	Management	Refunds Brady Kuno	Quarterly to DOH	Sent 7/31/2018	No quarterly reportin	No quarterly reportin	10/31/2018	No quarterly reportin	No quarterly reportin	1/14/2019

EQR Appendix D List of Periodic Reports to WDH from BCBSWY

Report Name: Monthly Reporting Log	Type	From	As of 7/2018 per WDH No Submission Required - On File with Review on Request Except Where Noted	CY 2018	CY 2019
Period Summary	Management	Planning and Implementation	By 15 calendar day of the month	12/5/2018	1/8/2019
Well Child Mailing List	Management	Planning and Implementation	By 15 calendar day of the month	12/5/2018	1/8/2019
Maternity	Management	Planning and Implementation	By 15 calendar day of the month	12/5/2018	1/8/2019
Inpatient Mental Health		Medical Review	By 15 calendar day of the month	12/3/2018	1/2/2019
Retroactive Cancellations -	Management	Refunds	By 15 calendar day of the month	12/10/2018	1/8/2019
Enrollment Income & Claims	Management	Actuary	By 15 calendar day of the month	12/10/2018	1/10/2019
Monthly Status Report Template	Status	Project Manager	Submitted at least 5 days prior to monthly status meeting via	12/12/2018	1/16/2019
Privacy & Security (HIPPA) Health	Status	Legal	Submitted at least 5 days prior to monthly status meeting	12/7/2018	1/7/2019
Risk Reporting	Status	Risk Management	Submitted at least 5 days prior to monthly status meeting	12/3/2018	1/7/2019
Customer Service Call Center Reporting-Health	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/5/2018	1/8/2019
Prior Authorizations Reporting-Health	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/10/2018	1/16/2019
Claims Performance Reporting-Health	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/11/2018	1/14/2019
Claims Performance Reporting Detail Health	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/11/2018	1/14/2019
Membership Performance Reporting-	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/11/2018	1/7/2019
Enrollment & Add On Verification Detail - Health	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/11/2018	1/15/2019
Marketing and Social Media Reporting-Health	Status	Operations	Submitted at least 5 days prior to monthly status meeting	12/11/2018	1/11/2019

EQR Appendix D List of Periodic Reports to WDH from BCBSWY

Fraud, Waste and Abuse Reporting - Health	Status	Corporate Operations	Submitted at least 5 days prior to monthly status meeting	12/3/2018	1/7/2019
Provider Disenrollment - Health	Status	Provider Relations	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/8/2019
Customer Service Call Center Reporting-Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/7/2019
Prior Authorizations Reporting-Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/7/2019
Claims Performance Reporting-Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/7/2019
Claims Performance Reporting Detail Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/7/2019
Membership Performance Reporting- Enrollment & Add On Verification Detail - Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/7/2019
Marketing and Social Media Reporting-Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting via Monthly Status	12/6/2018	1/7/2019
Fraud, Waste and Abuse Reporting - Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting via	12/6/2018	1/7/2019
Privacy & Security (HIPPA) - Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/8/2019
Provider Disenrollment - Dental	Status	Delta Dental	Submitted at least 5 days prior to monthly status meeting	12/6/2018	1/7/2019

EQR Appendix D List of Periodic Reports to WDH from BCBSWY

Annual Reporting Log	Type	Date Sent Jul-18
CAHPS Reporting - Calendar Year	Management	Sent 7/9/18
MACPRO Federal Reporting - ER Data	Management	No annual reporting due
CARTS Federal Reporting - *Membership by Age Category *Access to Primary Care *Well Child/PCP Summary	Management	No annual reporting due
CARTS Reporting Dental	Management	No annual reporting due
Additional CARTS Dental Reporting	Management	No annual reporting due
Annual Core Set KCC Data Reporting (Demographics, Claims)	Management	Sent 7/27/18
HealthStat-Medical and Dental	Management	No annual reporting due
Annual Certification that provider fees are sufficient to maintain an adequate network (SLA 28)	Status	7/12/2018
Demonstration of EPSDT Training and completion of annual survey: Upon operationalizing managed care services with 85% satisfaction rate (SLA/SOW 33)	Status	No annual reporting due
Annual Review of All Project Plans	Status	Resubmitted July-October 2018 per contract Requirements

EQR Appendix D List of Periodic Reports to WDH from BCBSWY

Report Name: Ad Hoc	Type	From	Date	Date Sent Dec-18	Date Jan-19
Fraud, Waste and Abuse	Status	Legal	Within 48 hours of discovery		
KCC Enrollment for Immunization	Management	Planning and Implementation			
Dental - HealthStat Data Request	Management	Delta Dental			
Physician Report by County - Medical	Management	Planning and Implementation	Requested 11/2/17		
October New Enrollment List	Management	Membership	Requested 11/6/17		
COB Data from Semi-Annual Report	Management	Planning and Implementation	Requested 1/31/18		
HealthStat Data-Medical & Dental	Management	BCBSWY and DDWY	Requested 2/23/18 Due 3/15/18		
ER Summary by Dx-1/18-3/18	Management	Planning and Implementation	Prepare again for 4/18-6/18		
Enrollment and Claims for Legislature	Management	Actuary & DD	Requested 12/20/18	12/21/2018	
CHIP Behavioral Health Legislation - SUPPORT Act	Management	QI	Requested 12/19/18		1/3/2019

APPENDIX V – Information Systems Capabilities Assessment

Attachment A: Tools for Assessing MCO Information Systems INFORMATION SYSTEM

CAPABILITIES ASSESSMENT (ISCA) TOOL

Responses from BCBSWY are in Red

This tool was developed in 2001 for inclusion in the original EQR Protocol package. This tool will be replaced with an updated tool after CMS completes a business intelligence analysis currently underway. The purpose of the tool remains the validation of information systems, processes, and data from providers and MCOs.

The ISCA is an information collection tool provided to the MCO by the State or its EQRO. The State or EQRO will define a time frame in which the MCO is expected to complete and return the tool. The MCO will record data on the provided tool. Documents from the MCO are requested throughout the tool and are summarized on the checklist at the end of this assessment tool. These documents should be attached to the tool and be identified as applicable to the numbered item on the tool (e.g., II.B.3 or IV.6). The tool itself is based on that produced by MEDSTAT Group, Inc., with some additional elements included to address the multiple purposes of performing assessments of information systems.

Note: The information requested below pertains to the collection and processing of data for an MCO's Medicaid line of business. In many situations, if not most, this may be no different than how an MCO collects and processes commercial or Medicare data. However, for questions which may address areas where Medicaid data is managed differently than commercial or other data, please provide the answers to the questions as they relate to Medicaid enrollees and Medicaid data.

A. Contact Information

Please insert (or verify the accuracy of) the MCO identification information below, including the MCO name, MCO contact name and title, mailing address, telephone and fax numbers, and E-mail address, if applicable.

MCO Name:	
Contact Name and Title:	Blue Cross Blue Shield of Wyoming
Mailing address:	PO Box 2266, Cheyenne WY 82003
Phone number:	307-634-1393
Fax number:	
E-mail address:	kenna.rotert@bcbwy.com

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0786. The time required to complete this information collection is estimated to average 1,591 hours per response for all activities, including the time to review

instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850

B. Managed Care Model Type (Please circle one, or specify other.)

MCO-staff model MCO-group model MCO-IPA model MCO-mixed model PIHP

Other - specify: Fee for Service

C. Year Incorporated 1976

D. Member Enrollment for the Last Three Years. Please define what types of plans fall under each category.

INSURER	**Year 1:_____**	**Year 2 _____**	**Year 3:_____**
Privately Insured			
Medicare			
Medicaid			
Other			

E. Has your organization ever undergone a formal information system capability assessment?

Circle a response: No

If yes, who performed the assessment?

When was the assessment completed?

NOTE: If your MCO's information has been formally assessed in the recent past (2 years or less), please attach a copy of the assessment report. Complete only those sections of the ISCA that are not covered by or have changed since the formal assessment was conducted.

EQR Appendix E ISCA as completed by BCBSWY

INFORMATION SYSTEMS: DATA PROCESSING PROCEDURES & PERSONNEL

1. What data base management system(s) (DBMS) do/does your organization use to store Medicaid claims and encounter data?

2. How would you characterize this/these DBMSs? (Circle all that apply.)

A. Relational	B. Network
C. Hierarchical	D. Flat File
E. Indexed	F. Proprietary
G. Other	H. Don't Know

3. Into what DBMS(s), if any, do you extract relevant Medicaid encounter/claim/enrollment detail for analytic reporting purposes?

4. How would you characterize this/these DBMS(s)? (Circle all that apply.)

A. Relational	B. Network
C. Hierarchical	D. Flat File
E. Indexed	F. Proprietary
G. Other	H. Don't Know

5. What programming language(s) do your programmers use to create Medicaid data extracts or analytic reports? How many programmers are trained and capable of modifying these programs? HMHS will provide.

6. Do you calculate defect rates for programs? HMHS will provide

7. Circle your response. Yes No HMHS

   If yes, what methods do you use to calculate the defect rate?

   What was the most recent time period?

   What were the results?

8. Do you rely on any quantitative measures of programmer performance? If so, what method(s) do you use to measure the effectiveness of the programmer? HMHS will provide

9. Approximately what percentage of your organization's programming work is outsourced?
   % HMHS will provide

10. What is the average experience, in years, of programmers in your organization?
    HMHS will provide

11. Approximately how many resources (time, money, etc.) are spent on training per

programmer per year? What type of standard training for programmers is provided? What type of additional training is provided? HMHS will provide

12. What is the programmer turnover rate for each of the last 3 years (new programmers per year/total programmers)? HMHS will provide
    Year 1 (20xx): _% Year 2 (20xx): _% Year 3 (20xx): %

13. Outline the steps of the maintenance cycle for your State's mandated Medicaid reporting requirement(s). Include any tasks related to documentation, debugging, roll out, training, etc. The level of detail should result in 10-25 steps in the outline. HMHS will provide

14. What is the process for version control when code is revised? HMHS will provide

15. How does your organization know if changes to the claims/encounter/enrollment tracking system affect required reporting to the State Medicaid program? What prompts your organization to change these systems? HMHS will provide

16. Who is responsible for your organization meeting the State Medicaid reporting requirements (e.g., CEO, CFO, and COO)? Government Programs Project Manager

    16a. Describe the Medicaid data processing organization in terms of staffing and their expected productivity goals. What is the overall daily, monthly, and annual productivity of overall department and by processor? HMHS will provide

    16b. Describe processor training from new hire to refresher courses for seasoned processors. HMHS will provide
    16c. What is the average tenure of the staff? What is annual turnover? HMHS will provide

17. Security

    17a. Describe how loss of Medicaid claim and encounter and other related data is prevented when systems fail? How frequently are system back-ups performed? Where is back-up data stored? How and how often are the backups tested to make sure that the back-up is functional? HMHS will provide
    17b. How is Medicaid data corruption prevented due to system failure or program error? HMHS will provide

    17c. Describe the controls used to assure all Medicaid claims data entered into the system is fully accounted for (e.g., batch control sheets). HMHS will provide

    17d. Describe the provisions in place for physical security of the computer system and manual files:

    - Premises
    - Documents

- Computer facilities
- Terminal access and levels of security HMHS will provide

17e. What other individuals have access to the computer system? Customers? Providers? Describe their access and the security that is maintained restricting or controlling such access. HMHS will provide

DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information, and data on ancillary services such as prescription drugs.

1. Administrative Data (Claims and Encounter Data)

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

A. Do you use standard claims or encounter forms for the following? If yes, please specify (e.g., CMS1500, UB 92).

DATA SOURCE	NO	YES	IF YES, PLEASE SPECIFY
Hospital		X	Both CMS1500 and UB92
Physician		X	Both CMS1500 and UB92
Drug		X	Both CMS1500 and UB92 (Medical)
Nursing Home		X	Both CMS1500 and UB92
Home Health		X	Both CMS1500 and UB92
Mental Health		X	Both CMS1500 and UB92
Dental		X	ADA Dental Claim Form

B. We would like to understand how claims or encounters are submitted to your plan. We are also interested in an estimate of what percentage (if any) of services provided to your enrollees by all providers serving your Medicaid enrollees are NOT submitted as claims or encounters, and therefore, are not represented in your administrative data. Please fill in the following table with the appropriate percentages:

EQR Appendix E ISCA as completed by BCBSWY

CLAIMS OR ENCOUNTER TYPES

MEDIUM	Hospital	PCP	Specialist Physician	Dental	Mental health/ Substance abuse	Drug	Other
Claims/encounters submitted electronically	95	77		88.2			
Claims/encounters submitted on paper	5	23		11.8			
Services not submitted as claims or encounters	0	0		0			
TOTAL	100%	100%	100%	100%	100%	100%	100%

C. Please document whether the following data elements (data fields) are required by you for providers, for each of the types of Medicaid claims/encounters identified below. If required, enter an "R" in the appropriate box.

CLAIMS/ENCOUNTER TYPES

DATA ELEMENTS	Hospital	Primary Care Physician	Specialist Physician	Mental Health/ Substance Abuse	Dental	Drug	Other
Patient Gender	R	R	R	R	R	R	
Patient DOB/Age	R	R	R	R	R	R	
Diagnosis	R	R	R	R			
Procedure	R	R	R	R	R	NDC	
First Date of Service					R		
Last Date of Service	R			R			
Revenue Code	R						
Provider Specialty		R	R	R			

D. How many diagnoses and procedures are captured on each claim? On each encounter?

EQR Appendix E ISCA as completed by BCBSWY

	Claim		Encounter	
	Diagnoses	Procedures	Diagnoses	Procedures
Institutional Data	All reported	All reported	All reported	All reported
Provider/Provider Group Data	All reported	All reported	All reported	All reported

E. Can you distinguish between principal and secondary diagnoses?

Circle your response. Yes

5a. If "Yes" to 5a, above, how do you distinguish between principal and secondary diagnoses? Follow standard ICD10 guidelines.

F. Please explain what happens if a Medicaid claim/encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-9/10 code? For both segments below the claim would not pass edit and would be rejected back to the Provider for both electronic and paper claims. Claims examiners do not alter claims.

Institutional Data:

Professional Data:

G. What steps do you take to verify the accuracy of submitted information (e.g., procedure code- diagnosis edits, gender-diagnosis edits, gender-procedure code edits)? All claim edits are built around procedure code for both segments below. To include but not limited to age and gender. Use CCI edits.

Institutional Data: Professional Data:

H. Under what circumstances can claims processors change Medicaid claims/encounter information? No circumstance – not allowed.

I. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's SSN is unknown, do you enter the member's SSN instead? Under no circumstance – claim would reject if a required field is missing.

10a. How are Medicaid claims/encounters received?

EQR Appendix E ISCA as completed by BCBSWY

SOURCE	Received Directly from Provider	Submitted through an Intermediary
Hospital	Yes	
Physician	Yes	
Pharmacy	Yes	PBM - Prime
Nursing Home	Yes	
Home Health	Yes	
Mental health	Yes	
Dental	Yes	Delta Dental
Other	Yes	Vision – Davis Vision

10b. If the data are received through an intermediary, what changes, if any, are made to the data? None

11. Please estimate the percentage of Medicaid claims/encounters that are coded using the following coding schemes: On the HMHS system the percentage has not yet been determined. Processes for some providers changed from paper to electronic due to system change 1/1/19. The boxes are only marked for what will be accepted.

CODING SCHEME	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure	Drug
ICD-9/10 CM	X	x	x	x	X
CPT-4	Optional	Optional	X	X	
HCPCS	Optional	Optional			
DSM-IV					
National Drug Code					X
Internally Developed					
Other (specify) Revenue	X	X			
Not required					
TOTAL	100%	100%	100%	100%	100%

EQR Appendix E ISCA as completed by BCBSWY

12. Please identify all information systems through which service and utilization data for the Medicaid population is processed. HMHS, Delta Dental, Prime, Davis Vision

13. Please describe any major systems changes/updates that have taken place in the last three years in your Medicaid claims or encounter system (be sure to provide specific dates on which changes were implemented).

    - New system purchased and installed to replace old system. 01/01/2019
    - New system purchased and installed to replace most of old system; old system still used. N/A
    - Major enhancements to old system (what kinds of enhancements?). N/A
    - New product line adjudicated on old system. N/A
    - Conversion of a product line from one system to another. N/A

14. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when? No

15. How many years of Medicaid data are retained on-line? How is historical Medicaid data accessed when needed? 3 years, data warehouse

16. How much Medicaid data is processed on-line vs. batch? If batch, how often are they run? 100% online, real time

17. How complete are the Medicaid data three months after the close of the reporting period? How is completeness estimated? How is completeness defined? Claims Triangle

18. What is your policy regarding Medicaid claim/encounter audits? Are Medicaid encounters audited regularly? Randomly? What are the standards regarding timeliness of processing? KCC claims are audited monthly by random sample with the timeliness standard of 30 days.

19. Please provide detail on system edits that are targeted to field content and consistency. Are diagnostic and procedure codes edited for validity? Yes, logic is built around CCI edits.

20. Please complete the following table for Medicaid claims and encounter data and other Medicaid administrative data. Provide any documentation that should be reviewed to explain the data that is being submitted. Need additional clarification for table below.

EQR Appendix E ISCA as completed by BCBSWY

	Claims	Encounters	Other Administrative Data
Percent of total service volume			
Percent complete			
How are the above statistics quantified?			
Incentives for data submission			

21. Describe the Medicaid claims/encounter suspend ("pend") process including timeliness of reconciling pended services. Adjudicator works suspended per the benefit within 30 day required timeliness.

22. Describe how Medicaid claims are suspended/pended for medical review, for non-approval due to missing authorization code(s) or for other reasons. What triggers a processor to follow up on "pended" claims? How frequent are these triggers? Based on system edits and Medical policy a claim will pend for review or deny. Pended claims are worked daily.

23. If any Medicaid services/providers are capitated, have you performed studies on the completeness of the information collected on capitated services? If yes, what were the results? N/A

24a. Identify the claim/encounter system(s) for each product line offered to Medicaid enrollees. (Note: Typically, there is just one product line offered to Medicaid enrollees, but there may be some circumstances in which a MCO offers additional product lines to the State (e.g., CHIP, partial risk products). N/A

Systems Used to Process	Product Line: KCC	Product Line: _____	Product Line: _____
Fee-for-service (indemnity) claims	X		

EQR Appendix E ISCA as completed by BCBSWY

Capitated service encounters			
Clinic patient registrations			
Pharmacy claims	X		
Other (describe)			

24b. If multiple systems are used to process claims for the Medicaid product line, document how claims/encounters are ultimately merged into Medicaid-specific files-- and on which platform? Medical, vision and pharmacy are merged in the HMHS system. Delta Dental claims are not merged.

Note which merges or data transfers or downloads are automated and which rely on manual processes. Medical, vision and pharmacy are automated.

Are these merges and/or transfers performed in batch? With what frequency? Daily/Realtime

24c. Beginning with receipt of a Medicaid claim in-house, describe the claim handling, logging, and processes that precede adjudication. When are Medicaid claims assigned a document control number and logged or scanned into the system? When are Medicaid claims microfilmed? If there is a delay in microfilming, how do processors access a claim that is logged into the system, but is not yet filmed? Paper claims are received in the mailroom, date stamped, scan through OCR same day, OCR assigns claim # (same day), logs the claim and then it is keyed onto HMHS. Electronic claims receive a claim # as soon as they enter the system.

24d. Please provide a detailed description of each system or process that is involved in adjudicating:

- A professional encounter(s) for a capitated service (e.g., child immunizations that arrive separately from the office visit.) N/A
- A hospital claim for a delivery or for a newborn that exceeds its mother's stay. Claim pends for review.

24e. Discuss which decisions in processing a Medicaid claim/encounter are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually. Is there a report documenting over-rides or "exceptions" generated on each processor and reviewed by the

claim supervisor? If so, please describe this report. Adjudicators/processors cannot override contract or approve claim beyond established benefit. The claim would remain pended for approval by medical staff.

24f. Are there any outside parties or contractors used to complete adjudication, including but not limited to:

- Bill auditors (hospital claims, claims over a certain dollar amount)
- Peer or medical reviewers Yes
- Sources for additional charge data (usual & customary)
- Bill "re-pricing" for carved out benefits (mental health, substance abuse)

How is this data incorporated into your organization's data? N/A

24g. Describe the system's editing capabilities that assure that Medicaid claims are correctly adjudicated

- Provide a list of the specific edits that are performed on claims as they are adjudicated and note: 1) whether the edits are performed pre or post-payment, and 2) which are manual and which are automated functions. CCI edits, pre-payment, post audit, random.

24h. Discuss the routine and non-routine (ad hoc or special) audits that are performed on claims/encounters to assure the quality and accuracy and timeliness of processing. Note which audits are performed per processor, which rely on targeted samples, and which use random sampling techniques. What is the total percentage of claims on-hand that are audited through these QA processes? How frequently? Processors do not perform audits. All audits occur in our Risk Assessment dept, they are targeted KCC claims, selected randomly.

24i. Please describe how Medicaid eligibility files are updated, how frequently and who has "change" authority. How and when does Medicaid eligibility verification take place? KCC files are receive via 834 file transfer weekly and add ons are received daily. The State's eligibility center has the change authority.

24j. How are encounters for capitated services handled by payment functions? What message appears to notify processors that they are handling a capitated service? N/A

24k. Describe how your systems and procedures handle validation and payment of Medicaid claims when procedure codes are not provided. If a procedure code is not provided the claim automatically denies back to the provider as an incomplete claim.

24l. Where does the system-generated output (EOBs, letters, etc.) reside? In-house? In a separate facility? If located elsewhere, how is such work tracked and accounted

for? Pittsburgh, PA. Through a verification process.

25a. Describe all performance monitoring standards for Medicaid claims/encounters processing and recent actual performance results. Performance monitoring occurs monthly per the SOW/SLA with the State. Document has been provided.

25b. Describe processor-specific performance goals and supervision of actual vs. target performance. Do processors have to meet goals for processing speed? Do they have to meet goals for accuracy? Yes, there is incentive pay for speed and accuracy.

25c. How is performance against targets figured into the official performance appraisal process? Into processor and supervisor compensation? Calculated annually during performance appraisal.

B. Enrollment System

1. Please describe any major changes/updates that have taken place in the last three years in your Medicaid enrollment data system (be sure to identify specific dates on which changes were implemented). For example:
    i. New enrollment system purchased and installed to replace old system 1/1/2019
    ii. New enrollment system purchased and installed to replace most of old system - is old system still used N/A
    iii. Major enhancements to old system (what kinds of enhancements?) N/A
    iv. New product line members stored on old system N/A

2. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid data that are collected? If so, how and when? No

3. How does your plan uniquely identify enrollees? Member ID and SSN

4. How do you handle enrollee disenrollment and re-enrollment in the Medicaid product line? Does the member retain the same ID? Receive weekly enrollment/disenrollment electronically from the State. Add-ons are received daily and are manually added within 12 hours of receipt. Member retains same ID in the KCC line of business.

5. Can your systems track enrollees who switch from one product line (e.g., Medicaid, commercial plan, Medicare) to another? Circle your response. Yes

    5a. Can you track an enrollee's initial enrollment date with your MCO or is a new

enrollment date assigned when a member enrolls in a new product line? Member receives a new enrollment date when they enroll in a new product line.

5b. Can you track previous claim/encounter data or are you unable to link previous claim/encounter data across product lines? Yes

6. Under what circumstances, if any, can a Medicaid member exist under more than one identification number within your MCO's information management systems? Under what circumstances, if any, can a member's identification number change? KCC members can exist on parent's plan or an individual exchange policy.

7. How does your MCO enroll and track newborns born to an existing Medicaid enrollee? Enrollment edibility is administrated by the State for KCC

7a. If your MCO has a Medicare product line, describe how your enrollment systems link individuals simultaneously enrolled in both your Medicare product line and the Medicaid plan product line. N/A

8a. Is claim/encounter data linked for Medicare/Medicaid dual eligible so that all encounter data can be identified for the purposes of performance measure reporting? N/A

Circle your response. Yes No

8b. Is claim/encounter data linked for individuals enrolled in both a Medicare and Medicaid plan so that all encounter data can be identified for the purposes of performance measure reporting? Circle your response. Yes No N/A

9. How often is Medicaid enrollment information updated? Daily file and weekly file

10. How is Medicaid continuous enrollment being defined? In particular, does your system have any limitations that preclude you from fully implementing continuous enrollment requirements exactly as specified in the State performance measure requirements? Monthly enrollment periods.

11. Please attach a copy of the source code that you use to calculate Medicaid continuous enrollment. MS Access queries.

12. How do you handle breaks in Medicaid enrollment--e.g., situations where a Medicaid enrollee is disenrolled one day and re-enrolled the next simply for administrative reasons? Does this affect your continuous enrollment calculations? No

13. Do you have restrictions on when Medicaid enrollees can enroll or disenroll? Please describe. Enrollment and disenrollment is handled by the State.

14. How do you identify and count Medicaid member months? Medicaid member years? Full month counts.

15. Please identify all data from which claims/encounters for the Medicaid product line are verified. Benefit, ID#, SSN#, DOB, gender, diagnosis, procedure code and medical policy.

16. Does the plan offer vision or pharmacy benefits to its Medicaid members that are different from the vision or pharmacy benefits offered to its commercial enrollees (within a given contract or market area)? Circle your response. Yes No If yes, explain:

    16a. If vision benefits vary by benefit package, outline the different options available. How are enrollees tracked?

    16b. If pharmacy benefits vary by benefit package, outline the different options available. How are enrollees tracked?

C. Ancillary Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as pharmacy or mental health/substance abuse.

1. Does your MCO incorporate data from vendors to calculate any of the following Medicaid quality measures? If so, which measures require vendor data? Yes, we receive data pharmacy data from Prime our PBM vendor.

NOTE: The measures listed in the following table are examples of measures that can be calculated with administrative data and align with CMS quality measurement initiatives as of 2011. The State and EQRO should tailor this table to list those measures that the State requires its MCO contractors to produce and any other measures in which the State is interested. Measures denoted with an asterisk are part of either the CHIPRA or Medicaid adult core measure sets.

MEASURE	VENDOR NAME
Childhood and Adolescent Immunization Rate(s)*	
Well Child Visits*	
Adolescent Well-Care Visits*	
Initiation of Prenatal Care	
Prenatal and Postpartum Care: Timeliness of Prenatal Care*	
Frequency of Ongoing Prenatal Care*	

EQR Appendix E ISCA as completed by BCBSWY

Developmental Screening In the First Three Years of Life*	
Cervical Cancer Screening	
Chlamydia Screening in Women*	
Child and Adolescent Access to Primary Care Practitioners*	
Percentage of Eligibles Who Received Preventive Dental Services*	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents*	
Breast Cancer Screening (Mammography	
Glycohemoglobin Monitoring	
Annual Pediatric Hemoglobin A1C Testing*	
Provider Certification	
Appropriate Testing for Children with Pharyngitis*	
Otitis Media with Effusion (OME) – Avoidance of Inappropriate Use of Systemic Antimicrobials in Children*	Prime
Percentage of Eligibles who Received Dental Treatment Services*	
Ambulatory Care: Emergency Department Visits*	
Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits*	
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication*	Prime
Follow-up After Hospitalization for Mental Illness*	

2. Discuss any concerns you may have about the quality or completeness of any vendor data. None

3. Please list subcontracted Medicaid benefits that are adjudicated through a separate system that belongs to a vendor. Prime and Delta Dental

4. Describe the kinds of information sources available to the MCO from the vendor (e.g., monthly hard copy reports, full claims data). Full claims data.

5. Do you evaluate the quality of this information? If so, how? Yes, by audit.

6. Did you incorporate these vendor data into the creation of Medicaid-related studies? If not, why not? Yes

D. Integration and Control of Data for Performance Measure Reporting

A. This section requests information on how your MCO integrates Medicaid claims, encounter, membership, provider, vendor, and other data to calculate performance rates. All questions relate to your current systems and processes, unless indicated otherwise.

Answers from perspective of HMHS platform and that WY staff will build the reporting using tools that are compatible with the HMHS platform data sources.

1. Please attach a flowchart outlining the structure of your management information systems, indicating data integration (i.e., claims files, encounter files, etc.). For an example of the minimum level of detail requested, please refer to the example on page 38. Label the attachment II.D.1.(?)

2. In consolidating data for Medicaid performance measurement, how are the data sets for each measure collected:

- By querying the processing system online? No.

i. By using extract files created for analytical purposes? If so, how frequently are the files updated? How do they account for claim and encounter submission and processing lags? How is the file creation process checked for accuracy? No

ii. By using a separate relational database or data warehouse (i.e., a performance measure repository)? If so, is this the same system from which all other reporting is produced? The expectation is to provide all KCC the reporting from the EDW (Enterprise Data Warehouse) and the CDM (Client Data Mart). The EDW contains only claim and enrollment information processed on the HMHS platform; where the CDM contains claim and enrollment information from both the legacy platform as well as from the HMHS platform. The legacy data will be representative of the years 2017-2018 services and enrollment periods

3. Describe the procedure for consolidating Medicaid claims/encounter, member, and provider data for performance measure reporting (whether it is into a relational database or file extracts on a measure-by-measure basis).

3a. How many different sources of data are merged together to create reports?

Medical claims adjudicated on the HMHS platformed are transformed and loaded into the EDW and CDM. RX claims processed by Prime Therapeutics and Routine Vision claims processed by Davis Vision are sent to HMHS where they are merged into the EDW and CDM.

Enrollment on HMHS platform is loaded into the EDW; however, it is merged with legacy enrollment information to be loaded in the CDM.
3b. What control processes are in place to ensure data merges are accurate and complete? Spot-checking the results compared to online systems, as well as expanding the personnel involved to provide cross check and balancing reports.

In order to verify the merged data from HMHS and the legacy platform, historical reports will be compared to those generated from the CDM.

3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in patient identifiers may lead to inclusion of non-eligible members or to double counting)?)? Multiple qualifiers are used to prevent including ineligible reporting items. These include the benefit plan used to adjudicate the claims as well as client/group KCC identifiers that are specifically associated to the KCC population. The benefit plan is unique to KCC and not shared/copied to other clients.

3d. Do you compare samples of data in the repository to transaction files to verify if all the required data are captured (e.g., were any members, providers, or services lost in the process)? HMHS has developed verification processes; however, not fully familiarized with them.

3e. Describe your process(es) to monitor that the required level of coding detail is maintained (e.g., all significant digits, primary and secondary diagnoses remain)?
There are claim adjudication modules that edit and validate codes presented on claims. In addition, there are audit functions that review the claim submission records to the finalized claims.

4. Describe both the files accessed to create Medicaid performance measures and the fields from those files used for linking or analysis. Use either a schematic or text to respond.
Group ID, Product ID, Member ID

5. Are any algorithms used to check the reasonableness of data integrated to report Medicaid performance measures? No

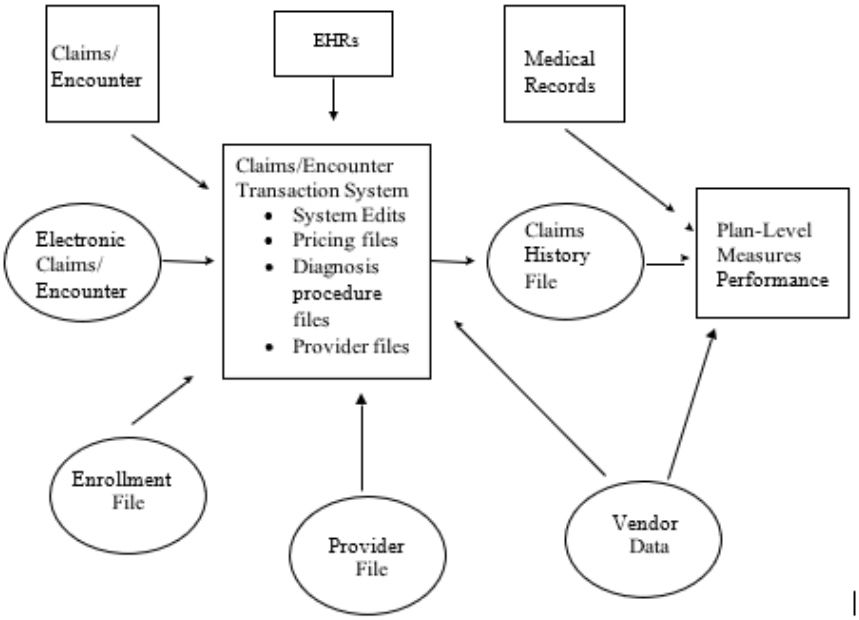
6. Are Medicaid reports created from a vendor software product? If so, how frequently are the files updated? How are reports checked for accuracy? No, they are created locally by in-house personnel.

7. Are data files used to report Medicaid performance measures archived and labeled with the performance period in question? The output reports are archived and labeled. The legacy

EQR Appendix E ISCA as completed by BCBSWY

Data Warehouse claim data has been retained for multiple years (up to 10 years). The EDW contains all the claim data that has been processed to-date on the HMHS platform; however, the CDM is still under construction to include the legacy claim information.

Performance Measure Data: Flowchart of Information System Structure



EQR Appendix E ISCA as completed by BCBSWY

Vendor Data Integration

7. Information on several types of external encounter sources is requested. In the table on the following page, for each type of delegated service, please indicate the following:

    - Second column: Indicate the number of vendors contracted (or subcontracted) to provide the Medicaid service. Include vendors that offer all or some of the service.

    - Third column: Indicate whether your MCO receives member-level data for any Medicaid performance measure reporting from the vendor(s). Only answer “Yes” if all data received from contracted vendor(s) are at the member level. If any encounter-related data is received in aggregate form, you should answer “No”. If type of service is not a covered benefit, indicate “N/A”.

    - Fourth column: Indicate whether all data needed for Medicaid performance measure reporting are integrated, at the member-level, with MCO administrative data.

    - Fifth and sixth columns: rank the completeness and quality of the Medicaid data provided by the vendor(s). Consider data received from all sources when using the following data quality grades:

        A. Data are complete or of high quality
        B. Data are generally complete or of good quality
        C. Data are incomplete or of poor quality

EQR Appendix E ISCA as completed by BCBSWY

In the seventh column, describe any concerns you have in ensuring completeness and quality of Medicaid data received from contracted vendors. If measure is not being calculated because of any eligible members, please indicate "N/A".

Medicaid Claim/Encounter Data from Vendors

Type of Delegated Service	Number of Contracted Vendors	Always receive member-level data from all vendor(s)? (Yes or No)	Integrate vendor data with MCO administrative data? (Yes or No)	Completeness of Data (A, B, or C)	Quality of Data (A, B, or C)	Rationale for Rating/ Concerns with Data Collection
Behavioral Health	N/A	N/A		N/A	N/A	
Family Planning	N/A	N/A		N/A	N/A	
Home Health Care	N/A	N/A		N/A	N/A	
Hospital	N/A	N/A		N/A	N/A	
Laboratory	N/A	N/A		N/A	N/A	
Pharmacy	Prime	Yes				
Primary Care	N/A	N/A		N/A	N/A	
Radiology	N/A	N/A		N/A	N/A	
Specialty Care	N/A	N/A		N/A	N/A	
Vision Care	Effective 1/1/2019 using Davis Vision	Yes		Minimal data to date, but seems to be complete	Minimal data to date, but seems to be accurate	
Dental for Children	Delta Dental	No		N/A	N/A	

EQR Appendix E ISCA as completed by BCBSWY

Performance Measure Repository Structure

If your MCO uses a performance measure repository, please answer the following question. Otherwise, skip to the Report Production section.

9. If your MCO uses a performance measure repository for Medicaid performance measures, review the repository structure. Does it contain all the key information necessary for Medicaid performance measure reporting? Yes

Report Production

10. Please describe your Medicaid report production logs and run controls. Please describe your Medicaid performance measure report generation process. Performance measure report generation is done monthly and reported to the State.

11. How are Medicaid report generation programs documented? Is there a type of version control in place? Logged monthly in project management and reported to the State.

12. How does your MCO test the process used to create Medicaid performance measure reports?

13. Are Medicaid performance measure reporting programs reviewed by supervisory staff? Yes

14. Do you have internal back-ups for performance measure programmers (i.e., do others know the programming language and the structure of the actual programs)? Is there documentation? HMHS

15. How are revisions to Medicaid claims, encounters, membership, and provider data systems managed? HMHS

PROVIDER DATA

Compensation Structure

The purpose of this section is to evaluate the Medicaid provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage of member months in your plan contributed by Medicaid members whose primary care providers and specialists are compensated through each of the following payment mechanisms.

PAYMENT MECHANISM	Primary Care Physician	Specialist Physician

EQR Appendix E ISCA as completed by BCBSWY

1. Salaried	0%	0%
2. Fee-for-Service, no withhold or bonus	94.5%	100%
3. Fee-for-Service, with withhold Please specify % withhold:	0%	0%
4. Fee-for-Service with bonus Bonus range:	5.5% $600/provider/quarter	0%
5. Capitated - no withhold or bonus	0%	0%
6. Capitated with withhold Please specify % withhold:	0%	0%
7. Capitated with bonus Bonus range:	0%	0%
8. Other	0%	0%
TOTAL	100%	100%

9. Please describe how Medicaid provider directories are updated, how frequently, and who has "change" authority. Provider directories are updated when BCBSWY is made aware of a change to a provider's demographic information. This data is recorded in a centralized provider data repository. This data is updated whenever a change needs to be made and is pushed out to our Provider Finder on a weekly basis. Members of our Provider Relations staff are the only individuals with authority to change provider data.

   9a. Does your MCO maintain provider profiles in its information system?

   Please circle response: YES

   9b. If yes to "a," what provider information is maintained in the provider profile database (e.g., languages spoken, special accessibility for individuals with special health care needs). Other? Please describe: All relevant information necessary for processing a claim along with additional information to assist the member in making decision when choosing a provider including: languages spoken, medical school, residency, board certifications, and accepting new patients.

10. How are Medicaid fee schedules and provider compensation rules maintained? Who has updating authority?
    KidCare Chip fee schedules are maintained by Provider Reimbursement focused staff in the Actuary department. This staff has updating authority for fee schedules.
    Provider compensation rules are maintained and updated in part as an element of the fee schedules by Actuary staff and in part by staff in other departments including Medical

Review, Provider Relations and Claims. Some provider compensation rules are maintained by staff at HMHS.

11. Are Medicaid fee schedules and contractual payment terms automated? Is payment against the schedules automated for all types of participating providers?

Yes, generally Kid Care claims are priced automatically however there are instances when a rate would manually be applied.

Summary of Requested Documentation

The documentation requested in the previous questions is summarized in the table below. Please label all attached documentation as described in the table, and when applicable by the item number from the ISCA (e.g., III.B.10). Remember, you are not limited to providing only the documentation listed below; you are encouraged to provide any additional documentation that helps clarify an answer or eliminates the need for a lengthy response.

Requested Document	Details
Previous Medicaid Performance Measure Audit Reports	Please attach final reports from any previous Medicaid performance measure audits in which your MCO participated during the past two years.
Organizational Chart	Please attach an organizational chart for your MCO. The chart should make clear the relationship among key Individuals/departments responsible for information management, including performance measure reporting.
Data Integration Flow Chart	Please provide a flowchart that gives an overview of the structure of your management information system. See the example provided in Section II-D. “Integration and Control of Data for Performance Measure Reporting.” Be sure to show how all claims, encounter, membership, provider, EHR, and vendor data are integrated for performance measure reporting.
Performance Measure Repository File Structure (if applicable)	Provide a complete file structure, file format, and field definitions for the performance measure repository.
Program/Query Language for Performance Measure Repository Reporting (if applicable)	Provide full documentation on the software programs or codes used to convert performance measure repository data to performance measures.
Continuous Enrollment Source Code	Attach a copy of the source code/computer programs that you use to calculate continuous enrollment for

EQR Appendix E ISCA as completed by BCBSWY

Requested Document	Details
Medicaid enrollees.	
Medicaid Member Months Source Code years for Medicaid enrollees.	Attach a copy of the source code/computer programs that you use to calculate member months, member
Medicaid Claims Edits	List of specific edits performed on claims as they are adjudicated with notation of performance timing (pre or post-payment) and whether they are manual or automated functions.
Statistics on Medicaid claims/encounters and other administrative data	Documentation that explains statistics reported in the ISCA.

EQR Appendix F PIPs as Submitted by BCBSWY

Name of Project:
• Increase the number of Kid Care children who have received a well-child visit or age aligned EPSDT screening.
Description and Background
• EPSDT age appropriate screenings are not being used to the extent possible to assure children's health outcomes and early identification of health issues. • Review claims to determine current EPSDT screening percentages among eligible enrollees. • Use benchmarking data to set improvement goal.
Describe the population affected by the Process Improvement Project
• All enrollees of the Kid Care CHIP program between ages 0-18 years.

Selection Process
• BCBSWY identified EPSDT screening as an important component of its Quality Monitoring and Assurance Plan. • Appropriate well-child checks and preventive screenings provided by EPSDT assure better health outcomes and identification of potential health problems that can be addressed when first identified.

Date reviewed by the Quality Management Committee	
To be reviewed at the October 2017 QMAC meeting.	

EQR Appendix F PIPs as Submitted by BCBSWY

Time Frames	
• This project begins July 1, 2017 and runs until June 30, 2018.	
Focus of Project	**Name of Senior Clinical Staff Person Involved**
• Clinical – related to a clinical improvement	**Joseph Horam, MD, Medical Director will oversee the project**
Baseline Measurement	
• Baseline will be established when claims analysis is completed for the period of January 1, 2017 through September 30, 2017.	
Data Collection	
• Quarterly claims reporting will evaluate Kid Care CHIP members ages birth – 18 years of age who have not had a well child visit or age aligned EPSDT screening services during the previous reporting period.	
Measurable Goal(s) toward improvement	
• Increase the number of children receiving EPSDT screening services each year.	
Projected Timeframe to Achieve Goals	
• June 30, 2018 (end of contract period)	

Name of Project:
• Reduce the number of Kid Care children who have a diagnosis of obesity and uncontrolled diabetes in order to improve health status.
Description and Background
• BCBSWY has identified uncontrolled childhood diabetes, both Type 1 and Type 2, ketoacidosis, and childhood morbid obesity as co-morbid conditions that can benefit from activities that can help prevent acceleration of each condition and the additional co-morbidities that can result.
Describe the population affected by the Process Improvement Project
• All enrollees of the Kid Care CHIP program between ages 5-18 years.

Selection Process
• This project was selected to improve the health of children who suffer from the complications of uncontrolled diabetes and obesity and who can benefit from targeted outreach. • Obesity and uncontrolled diabetes can result in significant complications and lifelong health impairments for children. • Controlling diabetes and obesity can help lower health utilization.
Date reviewed by the Quality Management Committee

EQR Appendix F PIPs as Submitted by BCBSWY

To be reviewed at the October 2017 QMAC meeting.	
Time Frames	
• This project begins July 1, 2017 and runs until June 30, 2018.	
Focus of Project	**Name of Senior Clinical Staff Person Involved**
• Clinical – related to a clinical improvement	**Joseph Horam, MD, Medical Director will oversee the project**
Baseline Measurement	
• Baseline will be established from analysis of claims for the period of Jan. 1, 2017 through Sept. 30, 2017.	
Data Collection	
• BCBSWY will use claims data and EPSDT screening information to determine those children diagnosed as having childhood morbid obesity and uncontrolled diabetes. • Quarterly, BCBSWY **will identify individuals in this population and perform targeted outreach using communication including mail, phone call, and other means of contact.**	
Measurable Goal(s) toward improvement	
• Reduction in number of Kid Care CHIP enrollees with diagnosis of obesity and uncontrolled diabetes to improve the child's health status and reduce future complications.	
Projected Timeframe to Achieve Goals	
• **June 30, 2018**	

EQR Appendix F PIPs as Submitted by BCBSWY

Name of Project:
• Increase compliance with annual pediatric dental screenings and EPSDT dental screenings.
Description and Background
• Using claims analysis identify Kid Care CHIP members who have not received an EPSDT or other pediatric dental screening. • EPSDT provides for age appropriate dental screenings.
Describe the population affected by the Process Improvement Project
• All enrollees of the Kid Care CHIP program between ages 1-18 years.

Selection Process	
• This project was selected to improve the health of children today and in the future and increase EPSDT dental screenings. • Oral health is very important and if ignored can lead to other diseases. • Beginning routine oral care at early stages in life can set up good future healthy habits and prevent future healthcare problems.	
Date reviewed by the Quality Management Committee	
To be reviewed at October 2017 QMAC meeting.	
Time Frames	

- **This project begins July 1, 2017 and runs until June 30, 2018.**

Focus of Project	Name of Senior Clinical Staff Person Involved
• Clinical – related to a clinical improvement	**Joseph Horam, MD, Medical Director will oversee the project**

Baseline Measurement

- **Baseline will be established using claims reporting for 2016 and for 2017. (See attached report)**

Data Collection

- **Data will be collected and analyzed for the period from January 1, 2017 thru December 31, 2017 and compared against the previous year to determine results.**

Measurable Goal(s) toward improvement

- **The goal for this PIP is to increase the participation rate of children receiving a pediatric dental/EPSDT screening.**

Projected Timeframe to Achieve Goals

- **June 30, 2018**