Anthem Medicaid

Professional provider workshop

Fall 2023

Agenda

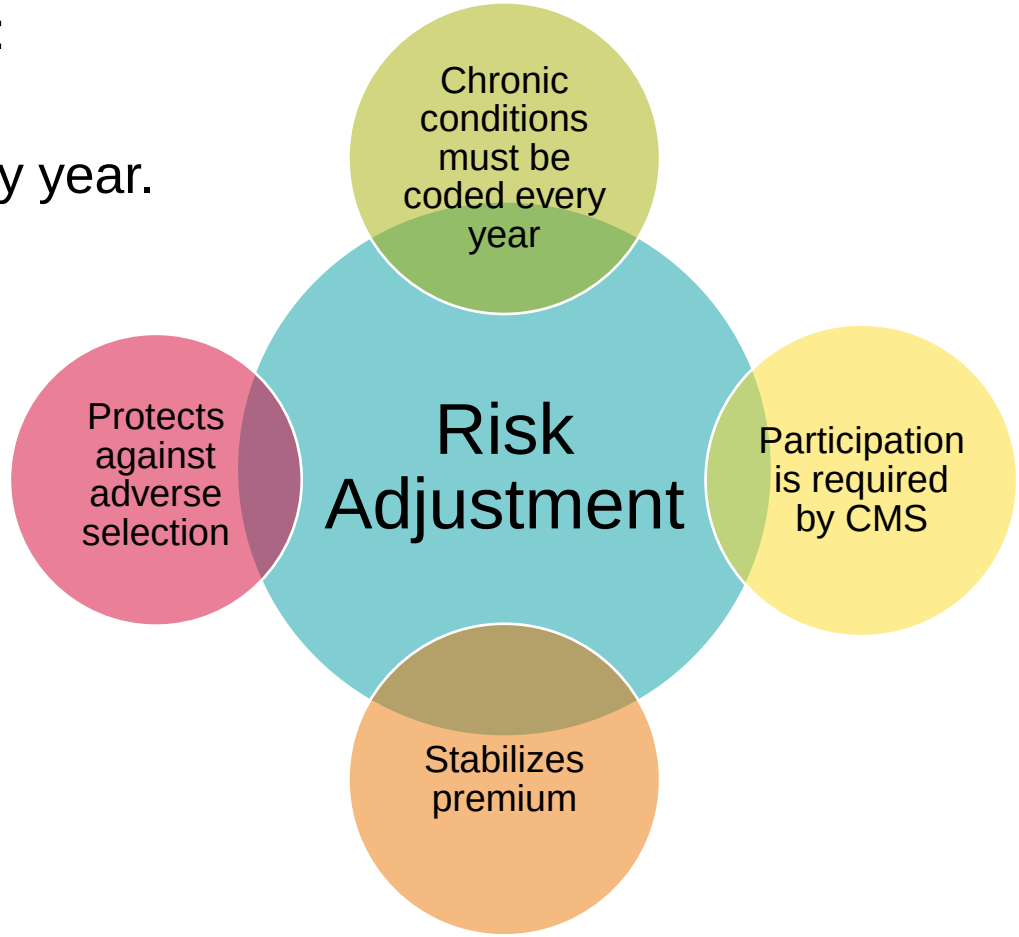
- Commercial Risk Adjustment
- Access and availability standards
- Availity:
  - Provider Data Management
- Claims resolution steps
- Appeals and grievances
- Medicaid redetermination
- Healthy Rewards

Commercial Risk Adjustment (CRA) overview

Background on CRA

Due to healthcare reform, healthcare insurers are no longer allowed to perform medical underwriting on individual and small group health insurance applicants. The *Affordable Care Act* (*ACA*) implemented a protective program called Risk Adjustment:

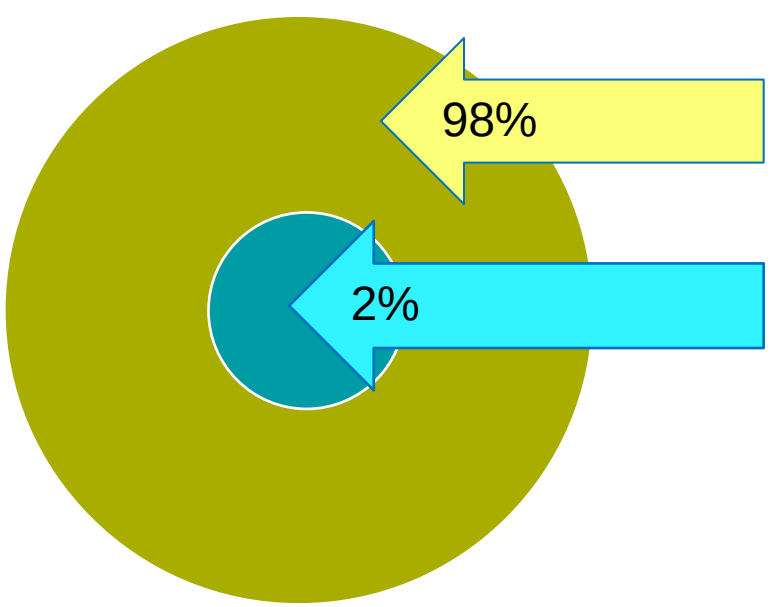
- CMS requires that chronic conditions are recorded every year.
- Guarantee issue allows coverage for all.
- Ensures stability in the markets.
- Protects against adverse selection.



ACA members

Approximately 20% of our members have a risk adjustable chronic condition.

The majority of these conditions will close on their own as members go in to see their providers. It's a small subset of that 20% that we actively engage with by encouraging them to go see their PCP.



98% of chronic conditions are processed through normal claims activity. Providers coding to the highest level of specificity closes these gaps.

CRA uses advanced analytics to identify the remaining 2% of members where care gaps have not been closed.

Risk Score Accuracy Improvement

- There are two distinct programs that work to improve risk adjustment accuracy and focus on performing appropriate interventions and chart reviews for patients with undocumented Hierarchical Condition Categories (HCC**), in order to document and close the coding gaps**.

  Retrospective:

  - Medical record collection
  - Medical records reviewed, Supplemental Diagnosis Codes, (SDCs) documented
  - SDCs submitted to CMS

  Prospective:

  - Member outreach encouraging PCP visits
  - Provider outreach sharing suspected conditions, and encouraging member visit
  - PCP alternatives to complete health assessments. *Note: If a member does complete an Inovalon Health Assessment and we attribute that patient to your practice, Inovalon sends a courtesy letter that includes the health assessment results:*
    - *In Home Assessments*
    - *Retail Clinic Health Assessment*
    - *Telehealth Health Assessment*

Retrospective program: Overview

- Record requests will be through multiple vendors and can be retrieved in multiple ways to relieve office abrasion:
  - Network providers — **may be PCPs, specialists, facilities, behavioral health, ancillary, etc.** — may receive letters from these vendors, requesting access to medical records for chart review.

- Chart retrieval timeline:
  - Retrospective chart review process runs from June 1, 2023, to April 30, 2024.
  - Final 2023 submission date to CMS is April 30, 2024.

- Chart retrieval methods:
  - Remote/direct access
  - Secure FTP website — MyFileGateway — self-service website to upload medical records. Easily set this up with a request to Mary.Swanson@anthem.com.
  - Various vendors

Prospective program: Overview

Prospective program ask of providers:

- Network providers — **usually primary care physicians** — may receive letters, phone calls, and emails from Inovalon, requesting that physicians:
    1. **Schedule a comprehensive visit** — **Telehealth visits are also an acceptable format** — with identified patients to confirm or deny if previously coded or suspected diagnoses exists

    and

    2. **Submit a health assessment** documenting the previously coded or suspected diagnoses (also called a *Subjective, Objective, Assessment* and *Plan SOAP*).

Incentives for properly submitted health assessments:

- **$100 for each health assessment properly submitted electronically through Inovalon's Converged Patient Assessment (formerly ePASS) system**

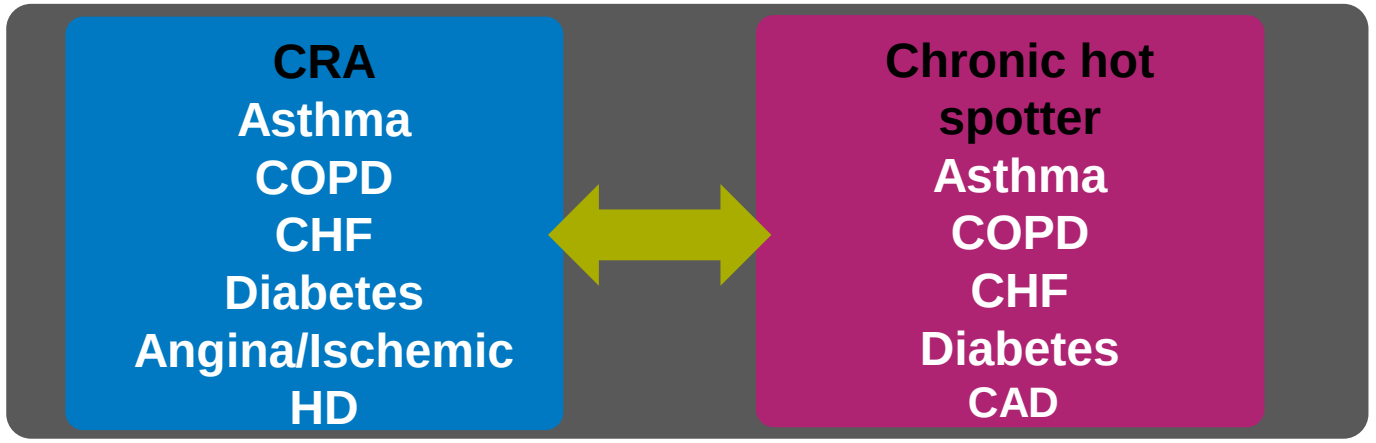
We have an alternative to Inovalon's Health Assessments that may also be eligible for an incentive:

- **EPIC *Patient Assessment Form (PAF)* — eligible for $50 incentive**
- **Providers own *Patient Assessment Form (PAF)* — eligible for $50 incentive**

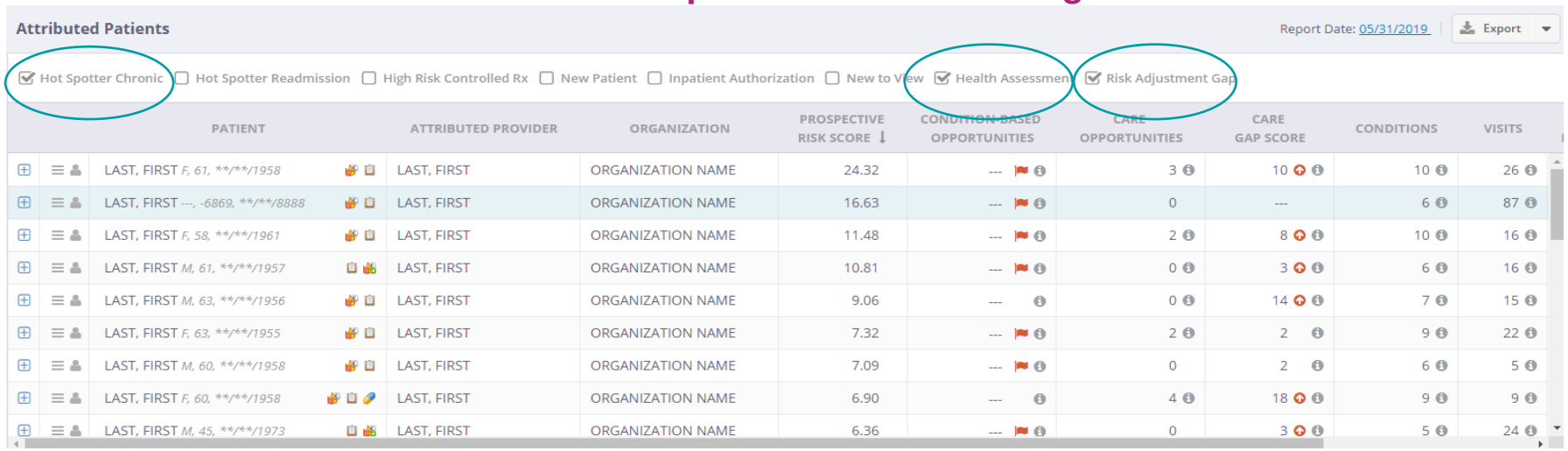
- **Secure FTP website: MyFileGateway**
- **Fax to CRA at 855-244-0926**
- **Secure email**

Email your provider relationship management representative, or contact Mary Swanson at Mary.Swanson@anthem.com if you have any questions on Inovalon's SOAPs or sending in alternative progress notes.

EPHC groups



When completing member outreach to close gaps in care, select simple filters for your attributed patients by Hot Spotter Chronic + Risk Adjustment Gap + Health Assessment = Population Health Management



Coding:
Importance of proper coding

We know your time is valuable.

If members are seen annually and **all** chronic conditions are coded to the highest level of specificity, no additional chart chases or paperwork is required. Proper coding is the key to minimizing risk adjustment requests.

Chronic conditions — Below are examples of chronic conditions that are frequently coded incorrectly:

Atrial Fibrillation	Congestive Heart Failure	Major Depressive Disorder
Bipolar Disorder	COPD	Malnutrition
Cardiomyopathy	Deep Vein Thrombosis (DVT)	Neoplasms
Chronic Kidney Disease	Diabetes Type 1 & 2	Rheumatoid Arthritis
Chronic Leukemia	Drug Use, Abuse and Dependence	Schizophrenia

Why it matters — because it allows us to properly document the health of our members and capture risk scores:

No Conditions Coded		Some Conditions Coded		All Conditions Coded	
Demographics		Demographics		Demographics	
Female 42, Silver Plan	0.433	Female 42, Silver Plan	0.433	Female 42, Silver Plan	0.433
HCC's		HCC's		HCC's	
		HCC037/Chronic Hepatitis	3.572	HCC002/Septicemia	10.404
		HCC082/Drug Psychosis or Dependent	3.381	HCC037/Chronic Hepatitis	3.572
				HCC055/Bone/Joint/Muscle Infections/Necrosis	6.243
				HCC082/Drug Psychosis or Dependent	3.381
				HCC135/Heart Infection/Inflammation	6.068
Interactions		Interactions		Interactions	
				Septicemia/Heart Infection	10.787
Risk Score	0.433	Risk Score	7.386	Risk Score	40.888

Provider access and availability requirements

Escalation contact list

CRA contact list	
Prospective program (*SOAP* notes/health assessments) Inovalons Converged Patient Assessment (formerly ePASS) tool gives you comprehensive information about your Anthem Blue Cross and Blue Shield Medicaid (Anthem) ACA patients, including potential preventative care gaps, and gives you the tool to completely document your patients' conditions using the Encounter *SOAP* note to confirm or refute that a potential preventive care gap exists.	**844-823-9408** providerengagement@inovalon.com
Retrospective program (chart reviews) Anthem CRA works with many vendors for chart requests for CRA members. Reference the contact information provided in the letter request received	Contact the vendor who sent the letter request, or you can contact Kris Bellerose, Anthem Central CRA State Lead at Kris.Bellerose@anthem.com
Anthem's CRA Network Education Representative Questions related to our CRA prospective programs	Mary.Swanson@anthem.com
Incentive questions — Questions related to incentive checks for completed health assessments should be directed to our CRA Incentive team	CRAincentives@anthem.com

Applicable to Medicaid and Commercial

- Anthem has established comprehensive and consistent mechanisms to ensure there are an adequate number of practitioners available to members within the Anthem provider network:
  - Anthem has adopted provider-to-member ratio standards as one way of achieving this.

- **Member after-hours access** — Members have access to quality, comprehensive healthcare services 24 hours a day, seven days a week. PCPs must have either a recording or an answering service for members during after-hours for assistance. The answering service forwards calls to the PCP or on-call physician or instructs the member that the provider will contact the member back within 30 minutes:
  - On an annual basis, Anthem conducts a random sample phone survey to ensure the accessibility standards are met as outlined above.
  - **providers.anthem.com/docs/gpp/KY_CAID_ProviderManual.pdf?v=202309282300**

Commercial policy: Page 7 of *Provider Manual*

anthem.com/docs/public/inline/PM_KY_00001_2020.pdf

OFFICE APPOINTMENT ACCESSIBIILITY Assessment of appointment timeliness to meet members needs	
Your office has the opportunity to be selected for a review of your scheduling of appointments by a vendor, NATO (North American Testing Organization) and the response to their inquiries is required as a part of this contract with Anthem, Inc. Please assist the surveyor during the phone call and participate in this quality program for your patients.	
MEDICAL APPOINTMENT ACCESS	***COMPLIANCE***
Emergency	Immediate access 24/7/365 or refer to ER or 911.
Urgent / Acute Care	Within 24 hours - ▪ Patients can be seen in the office by their doctor, covering doctor or another practitioner in the practice within the timeframe. ▪ Patient is directed to Urgent Care Center, ER or 911, as appropriate.
Non-Urgent *(Symptomatic or chronic)*	Within 72 hours – ▪ Patients can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.
Routine / Check-up	Within 10 business days ▪ Patients can be seen in the office by their doctor, another participating practitioner in the practice or a

Medicaid access and availability

The following table outlines appointment access standards:

General appointment scheduling (PCPs and all specialists, including vision, lab, and radiology)	
Emergency examination	Immediate access 24 hours, seven days a week
Urgent examination	Within 48 hours of request
Routine examination	Within 30 calendar days of request
Voluntary family planning: • Members under 18 years of age	Within 30 calendar days of request - If complete medical services cannot be provided on short notice, counseling and a medical appointment shall be provided right away, if possible, or within 10 calendar days of request
Prenatal	Within 14 calendar days of request
Third trimester	Within five calendar days of request
High risk pregnancy	Within 14 calendar days of request
Postpartum exam	Four to eight weeks after delivery
Behavioral health appointment standards	
Life-threatening emergency	Immediately
Crisis stabilization	Within 24 hours of request
Urgent behavioral health services	Within 48 hours of request
Outpatient treatment post-psychiatric inpatient care	Within seven calendar days from the date of discharge
Routine behavioral health visits, including the initial visit and follow-up visits	Within 10 calendar days of request
General and pediatric dental care appointment standards	
Urgent examination	Within 48 hours of request
New patient exam (dental)	Within 30 calendar days of request
Routine exam after initial diagnosis (dental)	Within 30 calendar days of request

Members after-hours access:

- Members have access to quality, comprehensive healthcare services 24 hours a day, seven days a week. PCPs must have either a recording or an answering service for members during after-hours for assistance that follow the acceptable after-hours arrangements:
  1. Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes
  2. Office phone is answered after hours by a recording directing the Enrollee to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of 30 minutes
  3. Office phone is transferred after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes
- For emergent issues, both the answering service and answering machine will direct the member to call **911** or go to the nearest emergency room.

Health Care Networks team information

- **Health Care Networks phone: 800-205-5870**, option **3**
- **Anthem Commercial *Provider Manual* link:**
  - https://www.anthem.com/docs/public/inline/PM_KY_00001_2020.pdf
- **Anthem Medicaid provider manual link:**
  - providers.anthem.com/docs/gpp/KY_CAID_ProviderManual.pdf?v=202309282300
- **All Anthem products updates — sign-up for eUpdates at:**
  - https://messageinsite.com/page.aspx?qs=5c591a8916642e730db697a6f39fdbd9716e914629d41b39

Provider data management

Provider data management and roster automation

Aligning with Availity provider data management (PDM)

Features and benefits of Availity PDM

What features does the Availity PDM application provide?

- It allows you to:
  - Update provider demographic information for all assigned payers in one location when using the **Standard PDM Experience**.
  - Attest and manage current provider demographic information.
  - Review the history of previously verified data when using the **Standard PDM Experience**.

Benefits to our care providers using Availity PDM

- The application will ensure the following:
  - Consistently updated data
  - Decreased turnaround time for updates
  - Compliance with federal and/or state mandates
  - Improved data quality through standardization
  - Increased provider directory accuracy

Aligning with Availity PDM (cont.)

Benefits to our care providers using Availity PDM (cont.)

Choice and flexibility to request data updates via:

- The **Standard PDM Experience**.
- Submitting a spreadsheet via a roster upload.
- The roster template is in 2 locations.
  1. Public website Provider Maintenance page
  2. Availity Payer Spaces under "Resource Tab"

Choose the option that makes the most sense for your care provider/organization.

Submitting a roster via Availity PDM

Submitting a roster via Availity PDM

1. **Utilize the *Roster Automation Standard Template***:
   - For your convenience, there is a standard roster Excel document.
   - Find it online on your market's public provider website where forms are housed, titled *Roster Automation Standard Template*.
2. **Follow the *Roster Automation Rules of Engagement*:**
   - A reference document, *Roster Automation Rules of Engagement*, is available to ensure error-free submissions, driving accurate and more timely updates through automation. More detailed instructions on formatting and submission requirements can also be found on the first tab of the *Roster Automation Standard Template* (User Reference Guide).
   - Find it online on your market's public provider website where forms are housed, titled *Roster Automation Rules of Engagement*.
3. **Once you've completed your roster, upload it via the Availity PDM application using the Upload Rosters option.**

Help & Training (cont.)

In addition, check out these quick demos on using the PDM application:

- Core PDM Detailed Overview (15 min)
- Business Profile Selection and Search and Add a Business (2 min)
- Manage Business (6 min)
- Mange Type 2 Providers (5 min)
- Manage Type 1 Providers (5 min)
- Submitting Verified Profile (40 sec)
- Reviewing History of Updates (1 min)

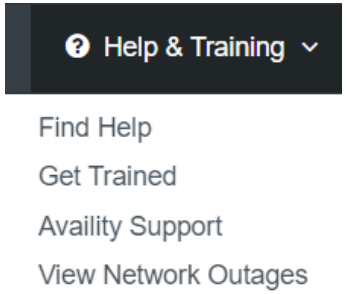
Availity Support to access online support tickets and online chat. You can also call **800-AVAILITY** (**282-4548**).

Roles and permissions needed:

- To access the PDM application, users must have the *Provider Data Management* role assigned to their account.
- If there is a third-party vendor handling provider demographics for your organization, your organization's administrator will need to assign them the PDM role.

Help & Training

- From the Availity Essentials home page, select **Help & Training.**
- Select **Find Help** to locate help articles and step by step guides:
  - Search **Provider Data Management.**
  - Select the **Provider Data Management** link.
  - **Provider Data Management — Quick start guide**



- Select **Get Trained** to access the Availity Learning Center (ALC). Here you can find courses, sign up for live webinars, or read forum posts:
  - Course: **Provider Data Management and Directory Verification — Training Demo**
  - Forum: **Why All the Directory Verification Requests and What's In It For Me?**

Claim resolution steps

Claim resolution steps

Have you tried these steps to resolve claim issues:

1. **Provider Chat: A fast, easy way to get your questions answered:**

- You now have a new option to have questions answered quickly and easily. With **Provider Chat**, providers can have a real-time, online discussion through a new digital service, **available through Payer Spaces and Claim Status on Availity**
- **Provider Chat** offers:
  - Faster access to Provider Services for all questions.
  - Real-time answers to your questions about prior authorization and appeals status, claims, benefits, eligibility, and more.
  - An easy-to-use platform that makes it simple to receive help.
  - The same high level of safety and security you have come to expect with Anthem.

Claim resolution steps (cont.)

2. **Secure Messaging:**

- Availity users can access **Secure Messaging** from Availity Essentials. The **Secure Messaging** tool allows providers to send questions about claims in a secured message to the payer. To access this tool, you must be registered with Availity and have access to **Claim Status**.
- To access your secure messages mailbox:
  - In the Availity Essentials navigation bar, select **Payer Spaces**, select the payer logo, and then select the payer space for your payer.
  - On the **Payer Space** page, select the **Resources** tab, and then select **Secure Messaging**.
- To send a secure message:
  - Submit a claim status inquiry for the claim you want.
  - On the claim status inquiry results page, click **Do you have a question about this claim?** under **Send a Secure Message.**

Claim resolution steps (cont.)

3. **Contact the appropriate Provider Services/Inquiry department:**

- Review the *Service Directory* to determine which Provider Inquiry number to call. Use the member's subscriber ID number (alpha prefix). If the alpha prefix is not in the *Service Directory*, it's considered **BlueCard**.
- Make sure to get the name of the Claims Department representative and call the reference number or reference the number from **Instant Chat** or **Secure Messaging** in Availity.

Service Directory

Claim resolution steps (cont.)

4. **Complete the claim escalation process:**

- Document your attempts for resolution on the below claim escalation form (spreadsheet) and send to your provider relationship management representative. Providers must complete the form accurately and list a valid reference number in column **N** or it will be rejected. The provider relationship management representative will then submit your spreadsheet to the Provider Issue Resolution (PIR) team for review.

- **Claims Template (locked) PIR**

Claim resolution steps (cont.)

5. Submit a claims dispute using the Claim Status Application (Availity) or appeal

- **Refer to the applicable *Provider Manual:***
  - Commercial — *Guide to Provider Complaints and Appeals:*
    - anthem.com/docs/public/inline/CLAIMS_CE_00001.pdf
  - Medicaid — *Guide to Provider Appeals:*
    - providers.anthem.com/docs/gpp/KY_CAID_PU_ProviderClaimPaymentAppeals.pdf?v=202111091852

Commercial and Medicaid appeal and grievances

A quick overview of the appeal and grievance policy

Appeals and grievances overview

- What are disputes?
- What are appeals and grievances (G&A)?
- Medicaid G&A:
  - When to submit?
  - Where to submit?
  - Proper documentation?
- Commercial G&A:
  - When to submit?
  - Where to submit?
  - Proper documentation?

Appeals and grievances

What are disputes?

- The *Claim Payment Dispute* is considered a reconsideration. This is the same for Medicare and Commercial networks. Providers and facilities will not be penalized for filing a *Claim Payment Dispute*, and no action is required by the member.
- Claim inquiry:
  - A question about a claim that does not result in changes
- Claim correspondence:
  - When Anthem requires more information to finalize a claim
- Clinical/medical necessity appeals:
  - An appeal regarding a clinical decision denial, such as authorization or claim that was denied for not medically necessary
- Claim payment reconsideration:
  - This is the first step in the *Claim Payment Dispute* process. The *Claim Payment Reconsideration* can be submitted via phone, the website, or in writing via a provider adjustment form. Be sure to keep all reference numbers. Providers have 24 months to submit a *Claim Payment Reconsideration*.

Commercial provider appeal

- Claim payment appeal:
  - If a provider or facility is dissatisfied with the outcome of a *Claim Payment Reconsideration* determination, providers and facilities may submit a *Claim Payment Appeal* through Availity or in writing.
  - Providers and facilities should submit a *Claim Payment Reconsideration* before submitting a *Claim Payment Appeal*. Once providers receive determination of their *Claim Payment Reconsideration*, they have 90 days to submit a *Claim Payment Appeal*.
  - When submitting a *Claim Payment Appeal*, providers should include as much information as possible to help Anthem understand why the provider believes the *Claim Payment Reconsideration* determination was in error.

Commercial provider dispute

Required documentation for *Claim Payment Dispute*:

- Provider or facility name, address, phone number, email, and either NPI or tax ID.
- The members name and their assigned member ID number.
- A listing of disputed claims which include the Anthem claim number and dates of service.
- All supporting statements and documentation.

How to submit a *Claim Payment Dispute*:

- Online through Availity by locating claim using the Claim Status Application to initiate.
- Mail all required documentation to:

Payment Dispute Unit

Anthem Blue Cross and Blue Shield

PO Box 10557

Atlanta GA 30348-5557

- Call the number on the back of the member ID card.

Commercial clinical appeals

- Clinical appeals can be used if providers or facilities disagree with clinical decisions. Clinical appeals are requests to change decisions based on whether services or supplies are medically necessary or experimental/investigative.
- Guidelines and timeframes for submitting clinical appeals:
  - Providers and facilities have 180 calendar days to file a clinical appeal from the date they receive notice of Anthem's initial decision
  - Send the appeal request to:

Anthem Blue Cross and Blue Shield

Attention: Grievances and Appeals

P.O. Box 105568

Atlanta GA 30348-5568

Medicaid clinical appeals

- Clinical appeals can be filed if you as the provider disagree with our decision not to approve the service that was requested. Appeal requests may be completed by the member, the member's representative, the provider, or the provider on behalf of the member with written member consent, either verbally or in writing. An appeal may be filed for any covered medical services, including EPSDT screenings and EPSDT Special Services.
- For an appeal of standard service authorization decisions, a member or provider must file an appeal, either verbally or in writing, within 60 calendar days of the date on the Anthem notice of action.
- To file a basic appeal, send a letter to:

Central Appeals Processing

Anthem Blue Cross and Blue Shield Medicaid

P.O. Box 62429

Virgina Beach, VA 23466-2429

- It is best to file an appeal in writing, but you can call **855-690-7784** (TTY **711**) to ask for one by phone. If you call to ask for an appeal, you must also send a written request within 10 calendar days of your verbal request.

Medicaid provider dispute

- The Health Care Network department helps the provider with claims payment and issue resolution.
- Contact Provider Services by calling **855-661-2028** and select the **Claims** prompt within Anthem's voice portal. If the appeal must be submitted in writing or if the provider wishes to use the written process instead of the verbal process, the appeal should be submitted to:

  Claims Appeal

  Anthem Blue Cross and Blue Shield Medicaid

  PO Box 62429

  Virginia Beach VA 23466-1599

- Written appeals and supporting documentation can also be submitted via *Provider Availity Appeals* at Availity.com. Use Claim Status to locate claim and select **Dispute** to initiate appeal. Navigate to *Appeals*, locate initiated claim, upload documentation, and submit.
- Payment appeals, whether verbal or written must be received by Anthem within 90 calendar days of the remittance date.

Medicaid external review

- If a provider does not agree with the determination of the appeal/dispute, the provider can then proceed to the Medicaid external review.
- The request for external review must be submitted to the MCO via one of the contact options designated below. DMS will also post the MCO contact information on their website at: chfs.ky.gov/agencies/dms. Requests are not accepted verbally. Additional information will not be considered by the third-party reviewer.
- Providers may submit a request for an external independent third-party review within 60 calendar days of receiving an MCO's final decision from the MCO's internal appeal process.

Medicaid external review (cont.)

Send your requests to one of the following:

- Email: KYExternalReview@anthem.com
- Fax: **502-212-7336**
- Mail:

Anthem Blue Cross and Blue Shield Medicaid
Central Appeals Processing
P.O. Box 62429
Virginia Beach, VA 23466-2429

- Electronic: Availity Essentials at availity.com/

Medicaid provider grievance

- A grievance is a notice of concern submitted to the health plan from a provider expressing dissatisfaction and requesting action, such as an investigation. A provider grievance may fall into one of the following categories: **Process/Polices**, **Claims Processing (Not Claim Appeal)**, **Communications**, **Fraud/Waste/Abuse**, **Contracting/Credentialing**, **Member**, or **Other**.
- The grievance is then assigned to the appropriate provider relationship management representative to investigate the provider's grievance and propose a resolution.
- The provider grievance form can be found at providers.anthem.com/ky.
- Submit a grievance in writing by letter or fax to:

Health Care Networks

Anthem Blue Cross and Blue Shield Medicaid

13550 Triton Park Blvd., Third Floor

Louisville, KY 40223

- Fax: **855-384-4872**

Where to find?

Further information regarding the G&A process can be found in the provider manuals located on the websites listed below:

- Commercial:
  - anthem.com/provider/policies/manuals/
- Anthem Blue Cross and Blue Shield Medicaid:
  - providers.anthem.com/kentucky-provider/resources/manuals-policies-guidelines

Medicaid redetermination

Medicaid redetermination

- The public health emergency (PHE) ended on May 11, 2023. As a result, all Medicaid beneficiaries will be going through an annual redetermination process.
- The KY Department for Medicaid Services (DMS) has resources available online: Medicaid Public Health Emergency Unwinding - KHBE (ky.gov)
- This link has member materials for your office: Kentucky Medicaid Renewals Resumed. As well as: How to Reinstate Your Medicaid (ky.gov)
- If a member is not eligible for Medicaid, they may still be eligible for insurance coverage from the Exchange. Brokers and KYnectors can help a member for free to determine the best option for them.

Medicaid redetermination (cont.)

- This will take the state, the providers, and the MCOs all working together to get the word out! The goal is continuous coverage for optimal health outcomes. DMS has received approval to extend coverage for 12 months for children.
- Anthem can help your group by providing a listing of members and their revalidation due date with DMS.
- Your provider relationship management representative can obtain the report at your request. Reach out to your representative with your tax ID number.

We look forward to taking care of your Anthem members under the Anthem Blue Cross and Blue Shield Medicaid plan.

Provider relationship management map

West team

Email: West.Team-KyProviderEngagement&Contracting@anthem.com

Phone: **800-205-5870, Opt. 3, Opt. 2**

Fax: **855-384-4872**

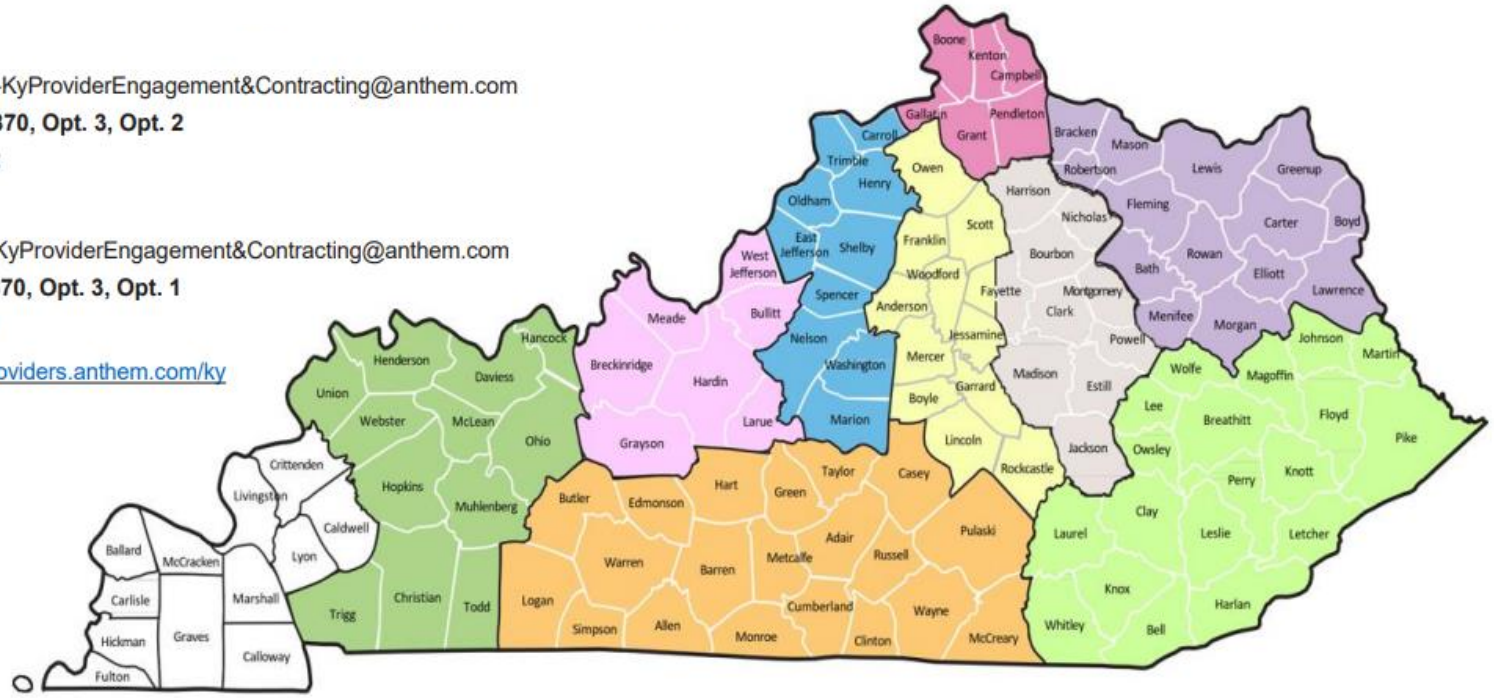
East team

Email: East.Team-KyProviderEngagement&Contracting@anthem.com

Phone: **800-205-5870, Opt. 3, Opt. 1**

Fax: **855-384-4872**

Website: https://providers.anthem.com/ky



West

Renee Griffith
renee.griffith@anthem.com
859-447-1188

Renee Griffith
renee.griffith@anthem.com
859-447-1188

Rick Chilton
Rick.chilton@anthem.com
502-381-0704

Rachel Buchanan
rachel.buchanan@anthem.com
502-263-3639

East

Melissa Lewis
Melissa.Lewis@elevancehealth.com
502-381-3515

Jason Day
Jason.Day@anthem.com
859-221-5293

Chad Glass
chad.glass@anthem.com
502-269-2042

Kasey Hegedus
Kasey.Hegedus@anthem.com
502-297-4805
**Fayette County: outside New Circle Rd*

Jennifer Kramer
JenniferA.Kramer@elevancehealth.com
270-570-1852
**Fayette County: inside New Circle Rd*

Julie Brooks
Julie.Brooks@anthem.com
502-396-5182

Healthy Rewards

Healthy Rewards

Healthy Rewards Program
— provider information

The Healthy Rewards Program helps you increase your quality scores while our members earn rewards.

Through our Healthy Rewards Program, members can earn $10 to $25 or more for getting certain health services. At the same time, you increase your practice's quality scores by providing members with the vaccinations, screening visits and medications they need.

When an Anthem Blue Cross and Blue Shield Medicaid (Anthem) member meets the eligibility criteria for the activities listed below and completes the service, they will earn the corresponding reward amount after the service is confirmed by the Claims department. The reward dollars are loaded into the member's Healthy Rewards portal and can be redeemed for a variety of retail gift cards. Please ensure you file your claims timely so our members can receive their rewards.

Healthy Rewards (cont.)

To help your practice, all Healthy Rewards activities are tied to HEDIS® scores and/or health initiatives. They include:

Healthy activity	Eligible member age	Reward	Frequency
Adult Well Visit	22 years and older	$25	1 per 12 months
Adult Dental Visit	21 years and older	$25	1 per 12 months
Child and Adolescent Wellness Visit	3 to 21 years	$30	1 per 12 months
Childhood Dental Visit	2 to 20 years	$30	1 per 12 months
Colorectal Screening	45 to 74 years	$50	1 per 12 months
Breast Cancer Screening	40 to 74 years	$25	1 per 12 months
Chlamydia Screening	16 to 24 years	$25	1 per 12 months
Cervical Cancer Screening	21 to 64 years	$40	1 per 36 months
HPV Vaccination	9 to 12 years	$50	1 per member
Flu Shot	2 years and older	$25	1 per 12 months
Diabetic Retinal Eye Exam	18 to 75 years	$25	1 per 12 months
Diabetic A1c Screening	18 to 75 years	$50	1 per 12 months

Healthy Rewards (cont.)

Healthy activity	Eligible member age	Reward	Frequency
Diabetic Medication Management and Adherence	18 to 75 years	$10	1 per quarter
High Blood Pressure Medication Refill	18 to 75	$10	1 per quarter
7-Day Follow-Up after Behavioral Health Discharge	6 years and older	$25	1 per quarter
Antidepressant Medication Management	18 years and older	$10	1 per quarter
Suicide Prevention Quiz	12 and older	$10	1 per 12 months
Tobacco Cessation (register at **Go.TheEXProgram.com/AnthemKY**)	21 years and older	$75	1 per lifetime
Initial and Annual Health Screener	All ages	$50	1 per 12 months
1st Prenatal Care Visit	13 to 55 years	$30	1 per pregnancy
Postpartum Care Visit	13 to 55 years	$50	1 per pregnancy
Well-Child Visits in the First 30 Months of Life	0 to 15 months	$10	4 per member
	15 months + 1 day to 30 months	$10	2 per member

Please remind your Anthem patients about the Healthy Rewards Program at their next office visit. By working together, we can encourage good habits and help our members get the right care, and you can improve your quality scores.

Healthy Rewards (cont.)

If your Anthem patients have questions regarding the program, please have them call Healthy Rewards at **888-990-8681 (TTY 711)** or visit the Benefit Reward Hub at **mss.anthem.com/ky** for more information.

To earn rewards, members must enroll in the program prior to or within 30 days of the date of service.

Thank you!

https://providers.anthem.com/ky

KYBCBS-CD-046479-23-SRS46479 January 2024