Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2017–2018 Internal Quality Assurance Program Compliance Review

for

Anthem Blue Cross and Blue Shield Healthcare Solutions

June 2018

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states contract with an external quality review organization (EQRO) to conduct an annual evaluation of their managed care organizations (MCOs) to determine the MCOs' compliance with federal and the State's managed care standards. The Nevada Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct external quality review (EQR) services for the Nevada Medicaid and Nevada Check Up, Nevada's Child Health Insurance Program (CHIP) managed care program.

The purpose of the state fiscal year (SFY) 2017–2018 Internal Quality Assurance Program (IQAP) Compliance Review was to assess each MCO's compliance with the compliance review standards found in 42 Code of Federal Regulations (CFR) §438 Subparts A–F and the State contract requirements found in the DHCFP Contract 3260. The SFY 2017–2018 IQAP Compliance Review focused on the requirements for provider network management found in Subparts A, C, and D. The review period was July 1, 2017, through December 31, 2017. This report details **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**'s) compliance with the following:

- State and federal managed care requirements, which were categorized into five contract standards referred to as ***IQAP Standards***.
- Outreach and educational materials associated with the provider manual, referred to as ***Checklists***.
- Operational compliance for credentialing, recredentialing, and delegated subcontractor oversight activities, referred to as ***File Reviews***.

Anthem had a composite score of 99.2 percent for all elements evaluated in the SFY 2017–2018 IQAP Compliance Review. With a couple of exceptions noted in this report, **Anthem** demonstrated strong compliance with the federal and State requirements contained in its managed care contract. Table 1-1 summarizes the overall ratings for **Anthem**'s IQAP standards, checklists, and file reviews for the SFY 2017–2018 IQAP Compliance Review.

Table 1-1—SFY 2017–2018 IQAP Compliance Review Results for Anthem

Overall Ratings for Anthem	
IQAP Standards Score	For the IQAP Standards, **Anthem** received a total score of **94.5%**.
Checklist Score	For the Checklist review, **Anthem** received a total score of **100%**.
File Review Score	For the File Review, **Anthem** received a total score of **100%**.

2. Background

In July 2016, the State of Nevada, Purchasing Division, on behalf of the DHCFP, a Division of the State of Nevada, DHHS, solicited responses from qualified vendors to provide risk-based capitated MCO services designed in support of the Title XIX (Medicaid) and Title XXI State Child Health Insurance Program (SCHIP, also known as "Nevada Check Up") medical assistance programs. In response to Request for Proposal (RFP) 3260, the DHCFP contracted with three MCOs to provide services to Medicaid and Nevada Check Up recipients.

Mandatory Activity

The BBA, Public Law 105-33, requires that states contract with an EQRO to conduct an annual evaluation of their MCOs to determine each MCO's compliance with federal and the State's managed care standards. The U.S. DHHS, Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR. The DHCFP contracted with HSAG to conduct EQR services for the Nevada Medicaid and Nevada Check Up managed care program.

According to the 42 CFR §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the state for access to care, structure and operations, and quality measurement and improvement. These standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438. To meet this requirement, the DHCFP contracted with HSAG to initiate a new three-year cycle of reviews starting in SFY 2017–2018, to complete a comprehensive review of compliance with State and federal standards within the three-year period. The full review schedule is detailed in Table 2-1.

Table 2-1—Nevada IQAP Compliance Review Cycle for MCOs

Standard	Year 1 SFY 2017 2018	Year 2 SFY 2018 2019	Year 3 SFY 2019 2020
Provider Network Management			
1. Credentialing and Recredentialing	✓		
2. Availability and Accessibility of Services	✓		
3. Subcontracts and Delegation	✓		
4. Provider Dispute and Complaint Resolution	✓		
5. Provider Information	✓		

Standard	Year 1 SFY 2017 2018	Year 2 SFY 2018 2019	Year 3 SFY 2019 2020
Member Services and Experiences			
1. Member Rights and Responsibilities		✓	
2. Member Information		✓	
3. Continuity and Coordination of Care		✓	
4. Grievances and Appeals		✓	
5. Coverage and Authorization of Services		✓	
Managed Care Operations			
1. Internal Quality Assurance Program			✓
2. Cultural Competency Program			✓
3. Confidentiality and Recordkeeping			✓
4. Enrollment and Disenrollment			✓
5. Program Integrity			✓

Purpose of the Review

The purpose of the SFY 2017–2018 IQAP Compliance Review was to determine **Anthem**'s compliance with federal and the State's managed care standards related to provider network management. In addition, HSAG conducted a review of individual files for the areas of credentialing, recredentialing, and delegated subcontractor oversight to evaluate **Anthem**'s implementation of the standards. Checklist reviews validated that the MCO apprised providers of the MCO's provider-related policies in the provider manual. The review period was July 1, 2017, through December 31, 2017.

3. Methodology

Compliance Review Process

The IQAP standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period—July 1, 2017, through December 31, 2017. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[3-1] to create the process, tools, and interview questions used for the SFY 2017–2018 IQAP Compliance Review.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and, State regulations and requirements outlined in the contract between the DHCFP and the MCOs. HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents that each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.

[3-1] 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. Accessed on: Mar 9, 2018.

- Generating a list of 10 sample cases plus an oversample of five cases for the credentialing and recredentialing file reviews and reviewing all delegated subcontractor contracts.

On-site review activities included:

- An opening conference with introductions as well as a review of the agenda and logistics for HSAG's on-site review activities.
- A review of the documents that HSAG requested each MCO to make available on-site.
- A review of the member cases that HSAG requested from each MCO.
- A review of the data systems that each MCO used in its operations, which includes but is not limited to care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- Interviews conducted with each MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

HSAG documented its findings in the data collection (compliance review) tool shown in Appendix A, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant. The results for the IQAP standards are noted in Table 3-1 of this report. The results for checklists and file reviews are summarized in Table 3-2 and Table 3-3, respectively, in the pages that follow.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created the corrective action plan (CAP) template, shown in Appendix B, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, the MCO must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **Anthem** must submit its CAP to the DHCFP **within 14 days of receiving this report**.

Description of Data Obtained

To assess the MCOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers and subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.

- Written plans that guide specific operational areas, which included but were not limited to: utilization management, quality management, care management and coordination, health management and service authorization, credentialing, cultural competency, delegation and contracting, and member education.
- MCO-maintained files for practitioner credentialing and recredentialing.
- MCO questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCOs' key staff members during the on-site review.

IQAP Standards, Checklists, and Files Reviewed

Table 3-1 through Table 3-3 list the standards reviewed, provider manual checklist, and files reviewed to determine compliance with State and federal standards.

Table 3-1—IQAP Standards

IQAP Standard #	IQAP Standard Name	Number of Elements
I	Credentialing and Recredentialing	15
II	Availability and Accessibility of Services	26
III	Subcontracts and Delegation	13
IV	Provider Dispute and Complaint Resolution	7
V	Provider Information	3
Total Number of IQAP Elements		**64**

Table 3-2—Provider Manual Checklist

Associated IQAP Standard #	Checklist Name	Number of Elements
V	Provider Manual	10
Total Number of Checklist Elements		**10**

Table 3-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
I	Initial Credentialing	160
I	Recredentialing	199
III	Delegated Subcontracts	33
Total Number of File Review Elements		**392**

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance defined as *either* of the following:
  - Compliance with all documentation requirements existed, but staff members were unable to consistently articulate processes during interviews.
  - Staff members were able to describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.
- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - No documentation was present, and staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* resulted in an overall finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that HSAG reviewers assigned for each requirement, HSAG calculated a total percentage-of-compliance score for each IQAP standard and an overall percentage-of-compliance score across the IQAP standards. HSAG calculated the total score for each standard by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 point), or *Not Met* (0 points), then dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the review areas by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores, then dividing the result by the total number of applicable requirements).

Provider Manual Checklist

For the checklist reviewed, HSAG reviewers scored each applicable element within the checklist as either *Yes*, the element was contained within the associated document; or *No*, the element was not

contained within the document. Elements not applicable to the MCO were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received *Yes* scores, then divided by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for credentialing, recredentialing, and delegated subcontractor oversight to verify that the MCO had put into practice what the MCO had documented in its policy. For credentialing and recredentialing, HSAG selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all the MCO's files. Rather, the file review highlighted instances that practices described in policy were not followed by MCO staff. Based on the results of the file reviews, the MCO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. For the delegated subcontractor file review, HSAG reviewed the delegated subcontractor files for all delegated subcontractors.

For the file reviews, HSAG reviewers scored each applicable element within the file review tool as either *Yes*, the element was contained within the file; or *No*, the element was not contained in the file. Elements not applicable to the MCO were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received a *Yes* score, then divided by the total number of applicable elements.

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services that the MCO provided to members, HSAG aggregated and analyzed the data resulting from desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCO's performance in complying with each IQAP standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each IQAP standard.
- The overall percentage-of-compliance score calculated across the IQAP standards.
- The overall percentage-of-compliance score calculated for each file review.
- The overall percentage-of-compliance score calculated for each checklist.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Partially Met* or *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to the DHCFP staff for their review and comment prior to issuing final reports.

Evaluation Ratings for Anthem

From a review of documents, observations, and interviews with key health plan staff as well as file reviews conducted during the on-site evaluation, the reviewers assigned **Anthem** a score for each element and an aggregate score for each standard. Further, HSAG reviewers scored each element within the checklists and file reviews.

IQAP Standards Review

Table 4-1 presents **Anthem**'s scores for the IQAP standards. Details regarding **Anthem**'s compliance with the five IQAP standards, including the score that **Anthem** received for each element within each standard, are found in Appendix A, SFY 2017–2018 IQAP Compliance Review Tool for **Anthem**.

Table 4-1—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Credentialing and Recredentialing	15	15	15	0	0	0	100%
II	Availability and Accessibility of Services	26	26	25	0	1	0	96.2%
III	Subcontracts and Delegation	13	13	10	1	2	0	80.8%
IV	Provider Dispute and Complaint Resolution	7	7	7	0	0	0	100%
V	Provider Information	3	3	3	0	0	0	100%
Total Compliance Score		**64**	**64**	**60**	**1**	**3**	**0**	**94.5%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA.* This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

A review of the IQAP standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. Of the 64 applicable elements, **Anthem** received *Met* scores for 60 elements, *Partially Met* scores for one element, and *Not Met* scores for three elements. The findings suggest that **Anthem** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate compliance with the contract. Further, interviews with **Anthem** staff showed that staff members were knowledgeable about the

requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

The areas with the greatest opportunity for improvement for IQAP standards were related to Standard II, *Availability and Accessibility of Services* and Standard III, *Subcontracts and Delegation*. For Standard II, *Availability and Accessibility of Services*, the Geo Access Report from third quarter 2017 showed there were a total of six members within the MCO's service area where the closest PCP was 64.3 miles away. Having PCPs assigned to members greater than 25 miles from the member's place of residence is acceptable if the MCO receives a written request from the member to access a PCP greater than 25 miles from the member's residence. **Anthem** staff members confirmed that the MCO did not have written request from the members to obtain services from a PCP that was greater than 25 miles from each member's residence.

For Standard III, *Subcontracts and Delegation*, **Anthem** provided agreements for eight delegated subcontractors, but there was no evidence submitted during the desk review or after the onsite review, as requested, to support approval was obtained from the DHCFP prior to implementing the delegated subcontracts.

Provider Manual Checklist Review

Table 4-2 presents the scores for the checklists. HSAG reviewed all requirements related to the Provider Manual to verify compliance with State and federal requirements. HSAG scored the elements required via the checklist. The checklist review area was scored based on the total number of **Anthem**'s compliant elements divided by the total number of applicable elements.

Table 4-2—Checklist Review

Associated IQAP Standard #	Description of File Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
V	Provider Manual	10	10	100%
	Checklist Totals	**10**	**10**	**100%**

The results generated by the checklists serve as additional indicators of the MCO's ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 10 elements reviewed for the checklist, **Anthem** received *Met* scores for all elements. The findings suggest that **Anthem** had strong compliance in each of the areas evaluated by the checklist and that **Anthem** developed the necessary manuals, handbooks, and policies according to contract requirements.

File Reviews

For the file reviews, each file review area was scored based on the total number of **Anthem**'s compliant elements divided by the total number of applicable elements for each individual file reviewed. Table 4-3 presents **Anthem**'s scores for the file reviews.

Table 4-3—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
I	Initial Credentialing	10	160	160	100%
I	Recredentialing	10	199	199	100%
III	Delegated Subcontractor	8	33	33	100%
	File Review Totals	**28**	**392**	**392**	**100%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Of the 392 total elements reviewed for the file reviews, **Anthem** received *Met* scores for all 392 elements. These results suggest that **Anthem** followed the policies it developed to operationalize the required elements of its contract.

Conclusions and Recommendations

Table 5-1 presents overall ratings for **Anthem** for IQAP Standards, Checklist, and File Reviews, as well as the overall composite score.

Table 5-1—Overall Rating for Anthem

IQAP Standards Score	For the IQAP Standards, **Anthem** received a total score of **94.5%**.
Checklist Score	For the Checklist review, **Anthem** received a total score of **100%**.
File Review Score	For the File Review, **Anthem** received a total score of **100%**.
Composite Score	**Anthem** received an overall rating of **99.2%** for all elements reviewed in the SFY 2017–2018 IQAP Compliance Review.

Anthem's overall result for the review of the IQAP standards in the SFY 2017–2018 IQAP Compliance Review was 94.5 percent. In addition, **Anthem** received a score of 100 percent for the file review, a score of 100 percent for the checklist review, and an overall composite score of 99.2 percent. The overall results demonstrated that **Anthem** had strong adherence to State and federal standards required by its contract with the DHCFP. **Anthem** developed the necessary policies, procedures, and plans to carry out the required functions of the contract; and the checklist and file review results demonstrated that **Anthem** staff appropriately operationalized the elements described in **Anthem**'s policies, procedures, and plans.

Compliance With IQAP Standards

Of the five standard areas reviewed, **Anthem** achieved 100 percent compliance on three standards, demonstrating performance strengths and adherence to all requirements measured in the areas of *Credentialing and Recredentialing, Provider Dispute and Complaint Resolution,* and *Provider Information.*

The *Availability and Accessibility of Services* and *Subcontracts and Delegation* standards had *Partially Met* or *Not Met* findings.

- HSAG recommends that **Anthem** prioritize improvement efforts to address *Not Met* elements, as well as *Partially Met* elements which did not achieve 100 percent compliance in the standards. These elements must be addressed in **Anthem**'s CAP (Appendix B), which is described in the "Corrective Action Plan" section of this report.

Compliance With Checklist Review

Anthem achieved 100 percent compliance for the checklist review, which demonstrates **Anthem**'s strong compliance with the requirements for information included in the provider manual.

Compliance With File Reviews

Anthem achieved 100 percent compliance on the initial credentialing file review and 100 percent compliance on the recredentialing file review, which indicates **Anthem**'s compliance with the credentialing and recredentialing file review standards.

Anthem received 100 percent compliance for all required elements related to the delegated subcontractor oversight file review. All files reviewed demonstrated **Anthem**'s compliance with the standards detailed in the contract.

Corrective Action Plan

Appendix B contains the CAP template that HSAG prepared for **Anthem** to use in preparing its CAP to be submitted to the DHCFP. The template lists each element for which HSAG assigned a score of *Partially Met* or *Not Met*, as well as the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **Anthem** must use this template to submit its CAP to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **Anthem**'s CAP must be submitted to the DHCFP **no later than 14 calendar days after receipt of this report**.

The following criteria will be used to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any corrective action plans that do not meet the preceding criteria will require resubmission by the organization until approved by the DHCFP. Implementation of the CAP may begin once approval is received. The DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **Anthem** in its submitted CAP.

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.214(a-b) *DHCFP Contract Section 3.16.2.1 (A)*	1. Provider Credentialing The MCO must have written credentialing and recredentialing policies and procedures for determining and assuring that all providers under contract to the MCO, including PCPs and Primary Care Specialists (PCSs), specialists, and other health care professionals, are licensed by the State and qualified to perform the services.	**Documents Submitted:** Policy 1 Credentialing Program Structure V.3 (Anthem Core).pdf Policy 2 Credentialing Program Provider Scope V.5 (Anthem Core).pdf Policy 3 Geographic CC V.3 (Anthem Core).pdf Policy 4.1 Pro Comp Conduct Criteria Hlth Deliv Orgs V.6 (A Core).pdf Policy 4.0.1 BH nonphysician Ed Criteria V.3 (Anthem Core).pdf Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf Policy 5 Initial Application V.3 (Anthem Core).pdf Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf Policy 10 Termination and Immediate Termination V.2 (Anthem Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		NV State Specific Regulatory or Contractual Addendum V.1 (Anthem Core).pdf **Description of Process:** Anthem's written policies describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and recredentialing of providers. These established policies and processes help to assure that quality of care is maintained or improved. Anthem will assure that all providers are appropriately licensed or registered in accordance with Nevada Division of Health and Human Services / Nevada Medicaid and any regulations thereunder or, if located in a jurisdiction outside of Nevada, in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices. In accordance with 42 C.F.R. §438.602 (b) each network provider is screened and enrolled as a Medicaid provider by Division of Health Care Financing and Policy (DHCFP) Nevada Medicaid Managed Care, and shall be periodically reenrolled.	
	Findings: The Credentialing Program Structure policy described the framework Anthem uses to conduct credentialing, recredentialing, and ongoing monitoring of network providers. The Credentialing Program Provider Scope policy further defined the category of providers that require credentialing, recredentialing, and ongoing monitoring and the Process for		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Verification of Data Elements policy outlined the steps Anthem takes to ensure providers are licensed by the State and qualified to perform the services under the contract.		
	Recommendations: None.		
42 CFR §438.214(d) *DHCFP Contract Section 3.16.2.1 (A)*	2. Providers Excluded from Participation in Federal Health Care Programs The MCO may not employ or contract with providers excluded from participation in federal health care programs under section 1128 of the Social Security Act.	**Documents Submitted:** Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf– Page 5 of 10 Policy 2 Credentialing Program Provider Scope V.5 (Anthem Core).pdf – Pages 1, 5, 6 of 11 Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf– Pages 6-9 of 9 Policy 5 Initial Application V.3 (Anthem Core).pdf– Page 7 of 10 **Description of Process:** Upon receipt of completed credentialing applications and during the recredentialing process, Anthem cross-references provider information with the Office of Inspector General's (OIG) LEIE and any available Nevada or state databases to identify excluded providers. These lists are also cross-referenced during the credentialing team's monthly	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		sanctions monitoring process. If Anthem identifies excluded providers from the LEIE or any other Nevada or state sources, the provider is given an adverse credentialing determination or is terminated from the network when identified during the recredentialing or monitoring process. In accordance with the federal and Nevada regulations, Anthem obtains required information from contracted providers and any individuals and/or entities having a five percent or more ownership or a controlling interest in the entity to verify if the individual(s) has any federal sanctions that would prohibit Anthem from reimbursing the provider. Newly contracted providers, re-contracted providers, providers requiring credentialing, and delegated groups must complete a Disclosure of Ownership and Control Interest Statement to be considered for participation in the provider network. Upon receipt of the completed Survey, Anthem reviews the information provided and enters the data into the CMS Sanction Tracking MS Access Database. On a monthly basis (every 30 days),	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		specific data are extracted and forwarded to Anthem's Sanction Monitoring Unit. The Sanction Monitoring Unit is responsible for identifying participating medical providers loaded in the provider databases that have been sanctioned by any of the State licensing boards or agencies. Based on information disclosed in the survey and notification of any positive match against a participating provider, Anthem reviews and determines an appropriate plan of correction, which may include termination of the provider agreement.	
	Findings: The Credentialing Program Provider Scope policy described Anthem's process for ensuring network providers meet standards of professional conduct and competence as determined by the Credentials Committee and any actions taken regarding the provider's licensure or participation in government programs, including Medicaid. During the onsite review, the MCO provided its OIG Sanctions Review for NV list demonstrating a monthly process for verifying providers are not excluded from participation in federal healthcare programs. Additionally, the MCO provided the document, Sanctions Review for NV list, which showed that licensed employees were also checked for sanctions and exclusions monthly.		
	Recommendations: None.		
42 CFR §438.12(a)(1) *42 CFR §438.214(c)* *DHCFP Contract Section 3.7.2.10*	3. Discrimination Against Providers The MCO: a) May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license, specialty, or certification; and	**Documents Submitted:** Policy 5 Initial Application V.3 (Anthem Core).pdf – Pages 8 & 9 of 10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) If the MCO declines to include an individual or groups of providers in its network, it must give the affected network provider(s) written notice of the reason for its decision.	In compliance with 42 CFR 438.214(c), Anthem does not discriminate against any potential provider on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein or against health care providers who serve high-risk populations or who specialize in the treatment of costly conditions. The credentialing processes do not discriminate against: (1) a health care professional solely on the basis of license or certification; or (2) a health care professional who serves high-risk populations or who specializes in the treatment of costly conditions. This information is not required or collected in the credentialing or recredentialing process. Gender and language capabilities of providers are provided to the members to meet their needs and preferences. The Credentialing Committee bases its decisions on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process. Anthem notifies the DHCP as required of any credentialing	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		applications that are denied due to program integrity-related issues. Anthem does not contract with providers who have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act.	
	Findings: The Initial Application policy included a statement that the MCO does not discriminate against any provider and provided its annual process for reviewing provider denials and terminations for consistency and lack of discrimination. The policy also included participation denial reasons. During the onsite review, Anthem provided a copy of a denial notice to a provider, which included the denial reason.		
	Recommendations: None.		
DHCFP Contract Section 3.16.2.1 (B)	4. Credentialing Criteria The MCO shall provide credentialing criteria for review and approval by DHCFP's Provider Enrollment unit ninety (90) calendar days prior to the start of the contract and ensure that all network providers meet the criteria.	**Documents Submitted:** Policy 1 Credentialing Program Structure V.3 (Anthem Core).pdf Policy 2 Credentialing Program Provider Scope V.5 (Anthem Core).pdf Policy 3 Geographic CC V.3 (Anthem Core).pdf Policy 4.1 Pro Comp Conduct Criteria Hlth Deliv Orgs V.6 (A Core).pdf Policy 4.0.1 BH nonphysician Ed Criteria V.3 (Anthem Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf Policy 5 Initial Application V.3 (Anthem Core).pdf Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf NV State Regulatory or Contractual Addendum V.1 (Anthem Core).pdf **Description of Process:** The credentialing process uses the Uniform Credentialing/Recredentialing Provider Application through the CAQH Universal Provider Data source to capture all required data and is compliant with NCQA and consistent with DHCFP requirements. The Credentials Committee and Provider Relations employees are supported by Anthem's national Credentialing department, which conducts all verifications and credential file preparation specified above.	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Primary Source Verification is performed using the information submitted by the provider in accordance with NCQA standards. The process includes verification of all required DHCFP information. The Credentialing and Recredentialing policies guide the credentialing process. This includes assessment of the applicant's training and education against training requirements established by the Credentialing Committee. If a practitioner fails to meet these training requirements, the application is closed and returned to the provider. Anthem queries and obtains information from: • The National Practitioner Databank to determine if any disciplinary actions were taken against the applicant in addition to any settled/closed malpractice cases • The Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE) database • System for Award Management (SAM)—the official federal system that consolidates the capabilities of EPLS, CCR/FedReg, and ORCA	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		• Various state and Department of Health Licensing Boards such as Medicine, Dentistry, and Psychology • Equivalent licensing boards for out-of-state providers and other applicable licensing entities Anthem's requirements meet and exceed NCQA standards, providing us an excellent framework to assess the clinical competence of each network provider and to make sure that standards are applied consistently. The health plan conducts site visits for any facility that does not have an accreditation or Medicare survey or that is identified on the Health Resources and Services Administration shortage designation list. The policies and procedures comply with NCQA, state, and federal laws and regulations, including 42 CFR 438.214 and 42 CFR 1002.3. Anthem notifies the DHCFP of any provider denied credentialing for program integrity-related reasons, including provider fraud, integrity, or quality. Anthem reports any changes in a mental health provider's credentialing information, including our	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		refusal to credential or re-credential a mental health provider.	
	Findings: During the onsite review, the MCO provided a letter it submitted to the DHCFP dated April 27, 2017, which demonstrated Anthem submitted its policy and procedure manual to the DHCFP for review and approval. Numerous credentialing policies were included as part of that submission.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15	5. Credentialing Provisions in IQAP The IQAP must contain provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the MCO, are qualified to perform their services.	**Documents Submitted:** Policy 4.1 Pro Comp Conduct Criteria Hlth Deliv Orgs V.6 (A Core).pdf Policy 4.0.1 BH nonphysician Ed Criteria V.3 (Anthem Core).pdf Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf Policy 5 Initial Application V.3 (Anthem Core).pdf Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf NV State Specific Regulatory or Contractual Addendum V.1 (Anthem Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		2017 NV AGP Quality Management Program Description.pdf 2016 NV AGP QM UM Program Evaluation.pdf **Description of Process:** The written policies describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and re-credentialing of providers. These established policies and processes help to assure that quality of care is maintained or improved. Anthem assures that all providers are appropriately licensed or registered in accordance with DHCFP and any regulations thereunder or, if located in a jurisdiction outside of Nevada in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices. In accordance with 42 C.F.R. §438.602 (b) each network provider is screened and enrolled as a Medicaid provider by DHCFP, and is periodically reenrolled. Anthem conducts Primary Source Verification using the information submitted by the provider in accordance with NCQA standards. The process includes verification of all required DHCFP information.	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Anthem queries and obtains information from: • The National Practitioner Databank to determine if any disciplinary actions have been taken against the applicant in addition to any settled/closed malpractice cases • The Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE) database • System for Award Management (SAM)—the official federal system that consolidates the capabilities of EPLS, CCR/FedReg, and ORCA • Various state and Department of Health Licensing Boards such as Medicine, Dentistry, and Psychology • Equivalent licensing boards for out-of-state providers and other applicable licensing entities The QM Program Description describes the credentialing process which initially determines applicant qualifications to provide services. Medicaid participation is required for contracting with the Anthem Network. Ongoing monitoring of the contracted provider includes the equality and appropriateness of patient care, clinical performance, and	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		utilization of resources, sanctions, sentinel events, peer review, Quality of Care issues, provider and member complaints/ grievances and other quality indicators.	
	Findings: The 2017 Quality Management Program Description described goals to improve the quality and safety of clinical care and services provided to Anthem's members through its providers. This document further described the ongoing activities to monitor care and service delivery and the assurances of effective credentialing and recredentialing processes for providers that comply with regulatory requirements.		
	Recommendations: None.		
42 CFR §438.214(b)(1) *DHCFP Contract Section 3.10.15.1*	6. Written Credentialing Policies and Procedures The MCO has written policies and procedures that include a uniform documented process for credentialing, which include the MCO's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. The MCO complies with the Nevada Administrative Code (NAC) 679B.0405 which requires the use of Form Nevada Department of Insurance (NDOI)-901 for use in credentialing providers.	**Documents Submitted:** Policy 1 Credentialing Program Structure V.3 (Anthem Core).pdf Policy 2 Credentialing Program Provider Scope V.5 (Anthem Core).pdf Policy 3 Geographic CC V.3 (Anthem Core).pdf Policy 4.1 Pro Comp Conduct Criteria Hlth Deliv Orgs V.6 (A Core).pdf Policy 4.0.1 BH nonphysician Ed Criteria V.3 (Anthem Core).pdf Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf Policy 5 Initial Application V.3 (Anthem Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf NV State Specific Regulatory or Contractual Addendum V.1 (Anthem Core).pdf NV Uniform Credentialing Application_Required NDOI-901.pdf NV Uniform Cred App NDOI-901_CAID_ProviderManual.pdf https://mediproviders.anthem.com/nv/pages/manuals-directories-training.aspx **Description of Process:** The credentialing of network providers is an important component of Anthem's contracting and quality management process. Anthem uses this process to monitor that all contracted providers and organizations provide services to our NV members are qualified to perform those services and deliver the best possible care. Each provider has a standard unique health identifier. Anthem has systems, employees, and policies and procedures in	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		place to accurately and timely credential and re-credential the full spectrum of physical and behavioral health providers in compliance with the DHCFP requirements. The written policies describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and recredentialing of providers. These established policies and processes help to assure that quality of care is maintained or improved.	
	Findings: The credentialing and recredentialing policies demonstrated Anthem's processes for credentialing, recredentialing, and conducting the ongoing monitoring of practitioners. The Credentialing section within Anthem's Medicaid Managed Care Provider Manual included the requirement to use the NDOI-901 form when credentialing providers in the State of Nevada.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.2	7. Credentialing Oversight The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	**Documents Submitted:** Policy 3 Geographic CC V.3 (Anthem Core).pdf Policy 18 Delegated Credentialing V.4 (Anthem Core).pdf Policy 18.1 Revocation of Delegation Agreements.pdf **Description of Process:** Anthem may elect to delegate credentialing and recredentialing activities to another entity.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		A description of the delegation oversight responsibilities and an overview of the delegation process are detailed in the quality improvement program as well as our policies and procedures. All delegates undergo an initial pre-delegation audit, complete with file audit and policy and procedures review, followed by a committee review and recommendation. Once delegated, each entity is required to submit regular updates and undergo annual re-assessments. Activities and responsibilities associated with delegated activities are documented within the written agreement between February 1, 2018, Amerigroup Community Care of Nevada, Inc., is now Anthem Blue Cross and Blue Shield Healthcare Solutions" and the subcontractor. The agreement requires the subcontractor and medical groups to provide reports related to the performance of their delegated activities and other obligations under the agreement. Amerigroup complies with NCQA standards for delegation oversight. Delegated subcontractors performing primary source verification on behalf a Delegated provider entity must comply with terms and conditions established and contractually	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		approved by "Effective February 1, 2018, Amerigroup Community Care of Nevada, Inc., is now Anthem Blue Cross and Blue Shield Healthcare Solutions". One of many conditions is the delegated subcontractor should be NCQA Accredited. Other minimum requirements are as follows: 1) Meet or exceed all Company and associated Health Plan 2) Meet or exceed all NCQA standards. 3) Meet or exceed all CMS regulations. 4) Comply with all applicable HIPAA requirements per Business Associate regulations. The Delegate/Vendor Oversight and Management Committee (DVOMC) has primary responsibility for overseeing Subcontractors serving multiple health plans. It is responsible for Subcontractor compliance with state, federal, NCQA, CMS, and individual program requirements, standards, and expectations, as well as any other applicable regulatory or accreditation standards. The DVOMC reports to the National Quality Improvement Committee quarterly.	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Credentials Committee policy indicated all determinations are made by the Credentials Committee. The Credentials Committee reports to Anthem's governing board and has been authorized by the board—under the direction of the Chief Medical Officer—to make these credentialing decisions. The policy further stated that the Credentials Committee reviews policies and procedures and the credentialing criteria at least annually. During the onsite review, Anthem submitted three consecutive sets of Credentials Committee meeting minutes, which included policy update information and subsequent motions to approve additions and modifications of language within specific credentialing-related policies.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.3	8. Credentialing Entity The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.	**Documents Submitted:** Policy 1 Credentialing Program Structure V.3 (Anthem Core).pdf Policy 3 Geographic CC V.3 (Anthem Core).pdf **Description of Process:** Anthem's national Credentials Committee is a policy-making body responsible for all credentialing policies and procedures across our organization. The Nevada Medical Director is a voting member of this committee and is responsible for setting clinical competence and conduct criteria for the entire Amerigroup provider network via this policy making body. Locally, Anthem has a Credentials Committee, including no less than two participating licensed Nevada physicians,	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		one of whom practices in the specialty type most frequently used by Anthem members. These physicians also operate within the scope of the credentialing program and have no other role in network management activities. The Chair of the Credentials Committee may appoint additional participating practitioners of other specialty types, as deemed appropriate. The committee also consults specialists as needed to complete the review of a provider's credentials. The Credentialing Committee bases their decisions on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process. Anthem notifies the DHCFP as required of any credentialing applications that are denied due to program integrity-related issues. Anthem does not contract with providers who have been excluded from participating in federal health care programs under Section 1128 or Section 1128A of the Social Security Act.	
	Findings: The Credentials Committee policy indicated all determinations are made by the Credentials Committee. The Credentials Committee reports to Anthem's governing board and has been authorized by the board—under the direction of		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	the Chief Medical Officer—to make credentialing decisions. During the onsite review, Anthem provided three sets of consecutive Credentials Committee minutes to demonstrate that the Credentials Committee makes credentialing recommendations and decisions.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.4	9. Scope of Credentialing The MCO identifies those practitioners who fall under its scope of authority and action. This includes, at a minimum, all physicians and other licensed independent practitioners included in the MCO's literature for recipients.	**Documents Submitted:** Policy 2 Credentialing Program Provider Scope V.5 (Anthem Core).pdf Policy 4.1 Pro Comp Conduct Criteria Hlth Deliv Orgs V.6 (A Core).pdf Policy 4.0.1 BH nonphysician Ed Criteria V.3 (Anthem Core).pdf Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf **Description of Process:** The written policies describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and recredentialing of providers. These established policies and processes help to assure that quality of care is maintained or improved. Anthem assures that all providers are appropriately licensed or registered in accordance with Nevada Division of Health and Human Services / Nevada Medicaid and any regulations thereunder or, if	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		located in a jurisdiction outside of Nevada, in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices. In accordance with 42 C.F.R. §438.602 (b) each network provider is screened and enrolled as a Medicaid provider by Division of Health Care Financing and Policy (DHCFP) Nevada Medicaid Managed Care, and shall be periodically reenrolled.	
	Findings: The Credentialing Program Provider Scope policy defined the category of providers requiring credentialing and recredentialing by the MCO and those who fall under its scope of authority and action.		
	Recommendations: None.		
42 CFR §1003.3 *DHCFP Contract Section 3.10.15.6 (D-E)*	10. Recredentialing: Reporting to the State The MCO's provider recredentialing must comply with 42 CFR §1003.3. If the MCO decredentials, terminates or disenrolls a provider the MCO must inform the State within 15 calendar days.	**Documents Submitted:** Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf NV State Specific Regulatory or Contractual Addendum V.1 (Anthem Core).pdf **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Our written policies describe if the Health Plan has denied credentialing or enrollment to a provider where the denial is due to Vendor concerns about provider fraud, integrity, or quality the Health Plan is required to report this to the State within 15 calendar days. If the Health Plan decredentials, terminates, or disenrolls a provider, the Vendor must inform the State, within 15 calendar days. If the decredentialing, termination or	
	Findings: The Additional State Specific Regulatory or Contractual Requirements for Nevada credentialing policy contained the requirements of this element. During the onsite review, Anthem confirmed that it notifies the State within 15 calendar days when a provider is decredentialed, terminated, or disenrolled.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.6 (E)	11. Recredentialing: Decredentialing, Terminating, or Disenrolling Providers If the decredentialing, termination, or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse the DHCFP notifies Health and Human Services-Office of the Inspector General (HHS-OIG).	**Documents Submitted:** Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf Policy 10 Termination and Immediate Termination V.2 (Anthem Core).pdf **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Additional State Specific Regulatory or Contractual Requirements for Nevada credentialing policy contained the requirements of this element. During the onsite review, Anthem confirmed that it notifies the State within 15 calendar days when a provider is decredentialed, terminated, or disenrolled so that the DHCFP may notify HHS-OIG.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.7	12. Delegation of Credentialing Activities If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities: a) There must be a written description of the delegated activities, and the delegate's accountability for these activities; b) There must also be evidence that the delegate accomplished the credentialing activities; and c) The MCO must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.	**Documents Submitted:** Policy 3 Geographic CC V.3 (Anthem Core).pdf Policy 18 Delegated Credentialing V.4 (Anthem Core).pdf Policy 18.1 Revocation of Delegation Agreements.pdf **Description of Process:** Anthem may elect to delegate credentialing and recredentialing activities to another entity. A description of the delegation oversight responsibilities and an overview of the delegation process are detailed in the quality improvement program as well as the policies and procedures. All delegates undergo an initial pre-delegation audit, complete with file audit and policy and procedures review, followed by a committee review and recommendation. Once delegated, each entity	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		must submit regular updates and undergo annual re-assessments. Activities and responsibilities associated with delegated activities are documented within the written agreement between February 1, 2018, Amerigroup Community Care of Nevada, Inc., now Anthem Blue Cross and Blue Shield Healthcare Solutions" and the subcontractor. The agreement requires the subcontractor and medical groups to provide reports related to the performance of their delegated activities and other obligations under the agreement. Amerigroup complies with NCQA standards for delegation oversight. Delegated subcontractors performing primary source verification on behalf a Delegated provider entity must comply with terms and conditioned established and contractually approved by "Effective February 1, 2018, Amerigroup Community Care of Nevada, Inc., now Anthem Blue Cross and Blue Shield Healthcare Solutions". One of many condition is the delegated subcontractor should be NCQA Accredited. Other minimum requirements are as follows:	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		1) Meet or exceed all Company and associated Health Plan 2) Meet or exceed all NCQA standards. 3) Meet or exceed all CMS regulations. 4) Comply with all applicable HIPAA requirements per Business Associate regulations. The Delegate/Vendor Oversight and Management Committee (DVOMC) has primary responsibility for overseeing Subcontractors serving multiple health plans. It is responsible for Subcontractor compliance with state, federal, NCQA, CMS, and individual program requirements, standards, and expectations, as well as any other applicable regulatory or accreditation standards. The DVOMC reports to the National Quality Improvement Committee quarterly.	
	Findings: Anthem's credentialing delegates include EyeQuest, Laboratory Corporation of America, Linkia, Medversant Technologies LLC, MedXM, and Online Care Network II, P.C. Anthem's written agreements with each of these delegates contained a written description of the delegated activities and the delegate's accountability for these activities, which included reporting requirements. The Delegated Credentialing policy included language to support a written agreement between the MCO and the delegated entity; the MCO's responsibility for oversight of the delegate's performance of delegated activities, which includes remediation steps for non-compliance with performance standards; and requirements for regular, ongoing		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	reports and a formal audit process. During the onsite review, Anthem provided documentation of each delegate's audit performance results.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.8	13. Retention of Credentialing Authority The MCO retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners. The MCO has policies and procedures for the suspension, reduction, or termination of practitioner privileges.	**Documents Submitted:** Policy 9 Re-credentialing V.4 (Anthem Core).pdf Policy 10 Termination and Immediate Termination V.2 (Anthem Core).pdf **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Termination and Immediate Termination policy described the procedures Anthem uses to terminate a provider for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence, or professional conduct. This policy further stated that the MCO reserves the right to take appropriate action to terminate the participation of practitioners when there is reason to do so. During the onsite review, Anthem indicated that all providers who apply for participation in the network are accepted if they meet the credentialing criteria.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.9	14. Reporting to Appropriate Authorities The MCO must ensure there is a mechanism for, and evidence of, implementation of the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.	**Documents Submitted:** NV State Specific Regulatory or Contractual Addendum V.1 (Anthem Core).pdf Policy 3 Geographic CC V.3 (Anthem Core).pdf Policy 4.1 Pro Comp Conduct Criteria Hlth Deliv Orgs V.6 (A Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Policy 4.0.1 BH nonphysician Ed Criteria V.3 (Anthem Core).pdf Policy 4.0.2 Cred of NPs Cert Nurse Midwives_PA V.5 (Anthem Core).pdf Policy 5 Initial Application V.3 (Anthem Core).pdf Policy 6 Process for Verification of Data Elements V.2 (Anthem Core).pdf Policy 6.1 Dist of App Info Related Prac Ed, Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf Policy 10 Termination and Immediate Termination V.2 (Anthem Core).pdf **Description of Process:** The written policies describe the scope, criteria, timeliness, and specific procedures for conducting credentialing and recredentialing of providers. These established policies and processes help to assure that quality of care is maintained or improved. Anthem assures that all providers are appropriately licensed or registered in accordance with DHCFP and any regulations thereunder or, if located in a jurisdiction outside of Nevada in accordance	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		with the health occupations regulatory requirements in the jurisdiction in which the provider practices. In accordance with 42 C.F.R. §438.602 (b) each network provider is screened and enrolled as a Medicaid provider by DHCFP, and is periodically reenrolled. Anthem conducts Primary Source Verification using the information submitted by the provider in accordance with NCQA standards. The process includes verification of all required DHCFP information. Anthem queries and obtains information from: • The National Practitioner Databank to determine if any disciplinary actions have been taken against the applicant in addition to any settled/closed malpractice cases • The Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE) database • System for Award Management (SAM)—the official federal system that consolidates the capabilities of EPLS, CCR/FedReg, and ORCA • Various state and Department of Health Licensing Boards such as Medicine, Dentistry, and Psychology	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		• Equivalent licensing boards for out-of-state providers and other applicable licensing entities Newly contracted providers, re-contracted providers, providers requiring credentialing, and delegated groups must complete a Disclosure of Ownership and Control Interest Statement (Survey) to be considered for participation in our provider network. Upon receipt of the completed Survey, we review the information provided and enter the data into the CMS Sanction Tracking MS Access Database. On a monthly basis (every 30 days), specific data are extracted and forwarded to our Sanction Monitoring Unit. The Sanction Monitoring Unit is responsible for identifying participating medical providers loaded in the provider databases that have been sanctioned by any of the State licensing boards or agencies. Based on information disclosed in the survey and notification of any positive match against a participating provider, we review and determine an appropriate plan of correction, which may include termination of the provider agreement.	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		If the Provider agreement requires termination due to the information disclosed or an identified sanction, we follow our established termination procedures. Written policies and procedures guide Anthem's process for reporting serious quality deficiencies resulting in suspension or termination of a practitioner to the appropriate DHCFP and federal authorities, including the Secretary of Health and Human Services and the Inspector General of Health and Human Services.	
	Findings: The Termination and Immediate Termination credentialing policy indicated Anthem complies with the reporting requirements of State licensing agencies, the National Practitioner Data Bank, and the Federal Healthcare Quality Improvement Act regarding adverse credentialing and peer review actions. The Quality of Care—Core Procedure policy also outlined the processes Anthem follows when a quality of care issue has been identified and its responsibilities for complying with regulatory requirements. Additionally, during the onsite review, Anthem clearly explained its procedures for reporting serious provider quality deficiencies.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.10	15. Provider Dispute Process The MCO must have a provider appeal process for instances wherein the MCO chooses to deny, reduce, suspend, or terminate a practitioner's privileges with the MCO.	**Documents Submitted:** Policy 13 Appeals Practitioners V.2 (Anthem Core).pdf Policy 14 Appeals Facilities V.2 (Anthem Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: The Practitioner may request a Reconsideration/Informal Review of a Credentials Committee decision which is adverse to the practitioner's network participation. This request must be in writing, sent via certified mail, and received by the credentialing department within thirty (30) calendar days (unless otherwise required by state regulation) of the date the Practitioner received the letter from Anthem with its determination based on the committee results. Additional information submitted subsequent to the initial decision is reviewed by the credentialing staff for Informal Review/ Reconsideration along with the information used as the basis for the initial decision and forwarded to the Credentials Committee for review at its next meeting. The Practitioner under review may provide written information, but is not present during the Credentials Committee meeting. For initial determinations, if the information submitted by the Practitioner.	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The HDO may request a Reconsideration/ Informal Review of the geographic Credentials Committee's decision if the decision of the geographic Committee is adverse to the provider. This request must be in writing, sent via certified mail, and received by the credentialing department within the thirty (30) calendar day period immediately following the date of the HDO's receipt of the letter from the Company (unless otherwise required by state regulation), with its determination based on the committee results. (See "Appendix A" for those plans with Meet and Confer Language in Provider Contract). Any additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/Reconsideration. The credentialing staff will review the information used as the basis for the initial decision, along with any additional information submitted by the HDO and if appropriate, forward the matter including any additional information submitted by the HDO to the geographic Credentials Committee at its next meeting. No representatives of the HDO shall be present during the Informal Review/Reconsideration.	

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		For initial determinations, if the information submitted by the HDO contains no new objective information, it may be presented in summary form.	
	Findings: The policies, Appeals Practitioner and Appeals Facility, described the provider appeal processes, which were different from the appeals process for members.		
	Recommendations: None.		

Results for Standard I: Credentialing and Recredentialing						
Total	Met	= 15	X	1.00	=	15.0
	Partially Met	= 0	X	.50	=	0.0
	Not Met	= 0	X	.00	=	0.0
	Not Applicable	= 0	X	.00	=	0.0
	Total Applicable	= 15	**Total Rate**		=	15.0
Total Rate ÷ Total Applicable = Total Score						100%

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.206(b)(1) *42 CFR §438.207(b)(2)* *42 CFR §438.208(b)(2-4)* *DHCFP Contract Section 3.4.2.7*	1. Network of Providers The MCO must maintain and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all eligible recipients enrolled in the MCO's managed care program.	**Documents Submitted:** PP Access to Care Standards.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf **Description of Process:** Anthem reviews geo access reports for network adequacy. If there are any providers/provider specialties needed for access standards, Anthem will contact relevant providers to see if they would like to join our network. When contracting with provider, the model provider agreements are used as the starting point for negotiations. Specific provider agreements can be made available on-site.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: Copies of the Ancillary Provider Agreement, the Facility Provider Agreement, and the Physician AHP Provider Agreement and the list of completed credentialing and recredentialing files confirmed that Anthem executed written contracts with providers serving the Medicaid population. The Geo Access Reports for the third and fourth quarters of 2017 provided evidence of the MCO's quarterly network monitoring.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.207(b)(1-2) *DHCFP Contract Section 3.4.2.7 (A-E)*	2. Establishing and Maintaining a Network of Providers In establishing and maintaining the network, the MCO must consider the following: a) The anticipated DHCFP recipient managed care enrollment; b) The numbers of network providers who currently are and are not accepting new Medicaid and Nevada Check Up recipients; c) The expected utilization of services, including a description of the utilization management software or other process used by the plan, taking into consideration the characteristics and health care needs of specific Medicaid and Nevada Check Up populations; d) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid covered services; and e) The geographic location of providers and enrolled recipients, considering distance (pursuant to NAC 695C.160), travel time, the means of transportation ordinarily used by recipients, and whether the location provides physical access for recipients with disabilities.	**Documents Submitted:** Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 PP Access to Care Standards.pdf PP Provider Availability.pdf **Description of Process:** The provider relations department reviews the provider network to ensure that there are adequate numbers of practitioners to service the member population. In addition to reviewing accessibility to the participating providers, geo access reports are reviewed and presented to the Quality Management Committee for discussion. These reports are used to identify gaps and target areas for possible recruitment of additional practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Geo Access Reports for the third and fourth quarters of 2017 provided evidence of the MCO's quarterly network monitoring of the geographic location of providers in relation to the enrolled members. The document, titled 2016 NV AGP QM UM Program Evaluation, included an appointment availability analysis to determine if appointment standards were met. The evaluation described the results of a provider accessibility survey conducted by Morpace, an accredited survey vendor. Morpace surveys providers to determine the accessibility and availability of appointments for Anthem members using computer-assisted telephone interviewing (CATI) methodology. The policy, Access to Care Standards, specified that the monitoring of provider office sites included ensuring that individuals with disabilities had physical access to provider offices. Further, the policy described Anthem's ongoing monitoring of the network, which included conducting office site visits and surveys to monitor compliance with appointment wait-time standards and providing an annual evaluation of access and availability of network services to the DHCFP.		
	Recommendations: None.		
42 CFR §438.207(c)(3)(i-ii) *DHCFP Contract Section 3.7.2.11*	3. Reporting Requirements The MCO must submit documentation to the State demonstrating the capacity to serve the expected enrollment when there has been a change in the MCO's services, benefits, geographic service area or payments, or enrollment of a new population in the network.	**Documents Submitted:** Section 4 Report 6B Network Adequacy Report 3Q2017.pdf Section 4 Report 6B Network Adequacy Report 4Q2017.pdf Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf Section 4 Report 6A Hospital Adequacy Report Q3 2017.pdf Section 4 Report 6A Hospital Adequacy Report Q4 2017.pdf **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Anthem demonstrates the MCO's capacity to service its expected enrollment based on the access requirements as set out by DHCFP by submitting reports and documentation to the State. These reports include geo access reports which demonstrate the distance a member must travel to access a provider and network adequacy reports demonstrating the number of members per provider.	
	Findings: The Access to Care Standards policy described Anthem's ongoing monitoring of the network, which included conducting office site visits and surveys to monitor compliance with appointment wait-time standards and providing an annual evaluation of access and availability of network services to the DHCFP. The Geo Access Reports, Section 4 Report 6A Hospital Adequacy reports, and Section 4 Report 6B Network Adequacy reports provided evidence that the MCO produced network monitoring reports that demonstrate the capacity to serve enrolled members. The DHCFP notification service delivery receipt emails from November 16, 2017, and February 15, 2018, provided evidence that Anthem submitted the required quarterly network adequacy reports to the DHCFP.		
	Recommendations: None.		
DHCFP Contract Section 3.4.2.8	4. Freedom of Choice of Providers The MCO must allow each recipient to choose his or her health care professional, including a PCP, to the extent possible and appropriate.	**Documents Submitted:** PP PCP Selection Assignment.pdf NV PCP Fax Change Form ENG FINAL MF_NV_0014-16.pdf NV PCP Fax Change From ENG FINAL MF-NV-0014-16.pdf NVNV_ProviderManual 2017.pdf – pg# 13 NVNV_MemberManual 2017.pdf – pg# 4-5	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: Anthem provides all members an opportunity to select their PCP from our provider network. When members do not select a PCP, they are assigned a PCP based upon the access requirements as set out by DHCFP. Members are allowed to select a new PCP by contacting Anthem and making a new selection. For quality purposes, Anthem tracks the reason for each change to identify any trends by PCP.	
	Findings: The PCP Selection Assignment policy Anthem Provider Manual, and Anthem Member Manual provided evidence that Anthem met the requirements of this element to allow members to choose his or her PCP.		
	Recommendations: None.		
42 CFR §438.206(b)(2) *DHCFP Contract Section 3.4.2.8 (E)*	5. Direct Access to Women's Health Specialists The MCO must provide female recipients with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the recipient's designated PCP, if that source is not a women's health specialist.	**Documents Submitted:** PP Access to Care Standards.pdf NVNV_ProviderManual 2017.pdf – pg# 27, 32 NVNV_MemberManual 2017.pdf – pg# 7 **Description of Process:** Female members may access any contracted OB/GYN for the following services: one well-woman examination per year; family planning; care related to pregnancy; care for all	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		gynecological conditions; and diagnosis, treatment and referral for any disease or condition reasonably considered by that woman to be within the scope of processional practice or a properly credentialed OB/GYN. Member can also access a family planning provider whether in or out of network with no referral for services pertaining to family planning.	
	Findings: The Access to Care Standards policy and the Anthem Member Manual included the provision to provide direct access to women's healthcare for women's routine and preventive healthcare services.		
	Recommendations: None.		
42 CFR §438.206(b)(3-4) *DHCFP Contract Section 3.4.2.10*	6. Second Opinions The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the recipient to obtain one outside of the network, at no cost to the recipient.	**Documents Submitted:** PP Second Opinion.pdf NVNV_ProviderManual 2017.pdf – pg 72 NVNV_MemberManual 2017.pdf – pg 7 **Description of Process:** Anthem provides the option for a second opinion for the member to make an informed choice. The second opinion is provided at no cost to the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Second Opinions policy Anthem Provider Manual, and Anthem Member Manual included the provisions for providing a second opinion from a qualified healthcare professional in network, or for arranging for the member to obtain one outside of the network at no cost.		
	Recommendations: None.		
42 CFR §438.206(b)(5) *DHCFP Contract Section 3.4.2.11*	7. Payment of Out-of-Network Providers The MCO must coordinate with out-of-network providers with respect to payment.	**Documents Submitted:** PP Out of Area-Out of Network Care.pdf Single Case Agreement Template.pdf PP Out of Network Authorization.pdf **Description of Process:** Anthem understands that is must coordinate with out-of-network providers with respect to payment. In order to do so, Anthem enters into Single Case Agreements or Out of Network Agreements with out of network providers offering care to Anthem members. The Single Case Agreement instructs provider on how/where to submit claims to Anthem, what the reimbursement rate will be for the services if over the standard reimbursement rate. In addition, there is information on the provider portal on how providers (network and non-network) can interact with Anthem. Out-of-network provider can register for access to the provider portal and obtain authorization and	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		claim information and Anthem policies and procedures. Out-of-network providers are also welcome to attend provider training sessions.	
	Findings: The Second Opinion policy noted that, for providers who render second opinions, Anthem makes the necessary arrangements for the appointment, payment, and reporting associated with the visit. The single case agreement template contained instructions for out-of-network providers to submit claims to Anthem for reimbursement. Interviews with staff members confirmed that Anthem completed single-case agreements for services provided by out-of-network providers. Anthem staff members stated that they completed an average of 21 to 25 single-case agreements per month, which were mostly for transplants. Anthem staff members stated that, for each provider that a single-case agreement is made, Anthem staff members will try to initiate a contract with the provider to have the provider join the network. Anthem staff members stated that most providers prefer a single-case agreement and are not actively pursuing contracts to join more networks.		
	Recommendations: None.		
42 CFR §438.206(c)(1)(i-vi) *DHCFP Contract Section 3.4.2.13*	8. Hours of Operation The MCO must: a) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid fee-for-service (FFS), if the provider services only Medicaid enrollees pursuant to 42 CFR §438.206. b) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;	**Documents Submitted:** 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 NVNV_ProviderManual 2017.pdf – pgs 166, 68-69, 73-75, 99 PP Access to Care Standards.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf Secret Shopper Call list Q3 2017.xlsx	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	c) Make services included in the RFP available twenty-four (24) hours per day, seven (7) days per week, when medically necessary; d) Establish mechanisms to ensure compliance by providers; e) Monitor providers regularly to ensure compliance and take corrective action if there is a failure to comply.	**Description of Process:** Network providers are expected to meet federal, state and Anthem standards as included in the provider manual with respect to member access. PCP providers must have after hours phone lines available to allow for 24 hour access. If the member calls a provider after hours, providers are expected to return calls within 30 minutes. On an annual basis, provider offices are reviewed telephonically to ensure compliance with access to care by Anthem's vendor, Morepace. The results of these reviews are documented and reviewed in the QMC meeting. On a weekly basis, all Provider Relations Representatives conduct 20 secret shopper calls to confirm appropriate appointment and availability standards in an effort to survey a larger denominator of providers than the annual surveys are able to capture. See attached sample secret shopper call log.	
	Findings: The Anthem Provider Manual contained the State-defined access standards, required providers to meet those standards, and instructed providers to ensure continuous 24-hour coverage. The Anthem Provider Manual included the statement that providers may not use discriminatory practices when treating Medicaid members, such as preference to other insured or private pay patients, separate waiting rooms, or appointment days. The Access to Care Standards policy outlined the mechanisms established to ensure provider compliance with access standards, which included the use of quarterly Geo		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Access Reports, annual after-hours appointment access surveys, and an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] survey as well as the review of complaints, grievances, and office site visits. Interviews with the provider services staff members confirmed that the provider relations department continually monitored the hours of operation to ensure access for Medicaid members. The policy, Access to Care Standards, also outlined the provision that Anthem would mandate corrective action for providers that failed to comply with the standards. Anthem staff members described the following activities to monitor provider availability: an annual appointment availability survey, secret shopper calls as a way to supplement the information in the annual survey, and site visits to provider offices. Anthem staff members stated that provider relations representatives visit high-volume providers at least quarterly and sometimes monthly, depending on need. Provider relations representatives visited small-volume providers once or twice per year, depending on need. Anthem staff members provided a system demonstration of SalesForce, which is the system used to track contacts and site-visits with providers.		
	Recommendations: None.		
42 CFR §438.114(b)(1) *DHCFP Contract Section 3.4.2.14*	9. Emergency Coverage The MCO must provide emergency coverage twenty-four (24) hours per day, seven (7) days per week. The MCO must have written policies and procedures describing how recipients and providers can obtain emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff.	**Documents Submitted:** PP Emergency Services Core Process.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf NVNV_ProviderManual 2017.pdf – pg# 14, 65, 71, 73 NVNV_MemberManual 2017.pdf – pg#36 PP Access to Care Standards.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

[A-1] CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: Anthem mandates that providers offer emergency coverage 24 hours a day 7 days a week. Please see attached policy.	
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to provide emergency coverage twenty-four hours per day, seven days per week with any qualified provider whether the provider is in-network or out-of-network. The Anthem Provider Manual and Anthem Member Manual also contained the provisions for emergency coverage, which were consistent with this element.		
	Recommendations: None.		
DHCFP Contract Section 3.4.2.14	10. Urgent Care The MCO must have written policies and procedures describing how recipients and providers can obtain urgent coverage after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.	**Documents Submitted:** PP Access to Care Standards.pdf 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 PP Access to Behavioral Health Care.pdf PP Clinical Information for Utilization Management Reviews.pdf PP Healthcare Management Services Denial Core Process.pdf NVNV_ProviderManual 2017.pdf – pgs 69, 75, & 99 NVNV_MemberManual 2017.pdf – pg 35 Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Physician-AHP Provider Agreement 0717.pdf **Description of Process:** Anthem has policies describing how members can obtain urgent care after business hours and on weekends. Members are informed of their options and how to access urgent services in the Member Handbook.	
	Findings: The policy, Access to Care Standards, described how members could access urgent care services after hours and on weekends. The Anthem Member Manual provided instructions to members on how to obtain urgent care services. The Ancillary Provider Agreement, Facility Provider Agreement, and Physician AHP Provider Agreement contained the requirement that access to urgent services be provided 24-hours a day, seven days a week.		
	Recommendations: None.		
DHCFP Contract Section 3.4.9	11. Out-of-Network Providers Covering services with out-of-network providers: a) If the MCO's provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the MCO must adequately and timely cover these services out of network for the recipient for as long as the MCO is unable to provide them. b) The MCO benefit package includes covered medically necessary services for which the MCO must reimburse certain types of providers	**Documents Submitted:** PP Access to Care Standards.pdf PP Out of Area-Out of Network Care.pdf Single Case Agreement Template.pdf **Description of Process:** Please see the attached policies. When Anthem must utilize the services of an out of network provider to offer care to our members, we enter into a single case agreement with the provider if they do not accept our standard of	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	with whom formal contracts may not be in place. c) The MCO must also coordinate these services with other services in the MCO benefit package.	100% NV Medicaid rates. If they accept our standard rates, then an out of network authorization is all that is required.	
	Findings: The policy, Out of Area, Out of Network Care, described the necessary procedures for Anthem to follow to provide access to covered services with out-of-network providers if the services cannot be provided by in-network providers. The policy also described Anthem's policy to coordinate the services with other services offered in the benefits package and reimburse out-of-network providers through single-case agreements.		
	Recommendations: None.		
DHCFP Contract Section 3.6.3.2	12. Twenty-five (25) Mile Rule The MCO must offer every enrolled recipient a PCP or Primary Care Site located within a reasonable distance from the enrolled recipient's place of residence, but in any event, the PCP or PCS may not be more than twenty-five (25) miles from the enrolled recipient's place of residence per NAC 695C.160 without the written request of the recipient.	**Documents Submitted:** PP PCP Selection Assignment.pdf PP Access to Care Standards.pdf Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf **Description of Process:** Anthem offers access to a PCP within 25 miles of a member's home. When a member does not select a PCP, the member is auto-assigned to a PCP that is within 25 miles from the member's home. In those instances where this is not met, it is due to geographical limitations of the county and location of PCP's in that area. In both Clark and Washoe County there are several	☐ Met ☐ Partially Met ☒ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		members that are not within 25 miles. That is because there are no PCP offices located within 25 minutes of these members home, they are very remote residences.	
	Findings: The policy, Provider Availability, provided evidence of the MCO's policy to ensure that at least one PCP is located within 25 miles of each member's home. The Geo Access Reports provided evidence that the majority of members had at least one PCP within 25 miles of their place of residence. The Geo Access Report from third quarter 2017 showed that there was a total of six members in Laughlin where the closest PCP was 64.3 miles away. Anthem staff members stated that there were no primary care physicians within a 25-mile radius of each member's residence. Anthem staff members confirmed that the MCO did not have written requests from the members to obtain services from a PCP that was greater than 25 miles from each member's residence. A similar finding was found in the SFY 2014–2015 IQAP Compliance Review and HSAG made the following recommendation, "Amerigroup needs to ensure that all members have a PCP that is 25 miles or closer to the member's place of residence unless Amerigroup has a written request from the member to allow assignment to a PCP that is greater than 25 miles from the member's place of residence." It did not appear, through a review of documentation and interviews with staff members, that Anthem had processes in place to seek each member's request to allow assignment to a PCP that is greater than 25 miles from each member's residence.		
	Recommendations: Anthem must ensure that all members have a PCP that is 25 miles or closer to each member's place of residence unless Anthem has a written request from the member to allow assignment to a PCP that is greater than 25 miles from the member's place of residence.		
DHCFP Contract Section 3.7.5.1–3.7.5.5	13. Access and Availability The MCO shall: a) Ensure adequate physical and geographic access to covered services for enrolled recipients;	**Documents Submitted:** Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards; c) Partner actively with DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP recipients. d) Assure access to health screenings, reproductive services and immunizations through county and state public health clinics. e) Promote care management and early intervention services by completing welcome calls and/or visits to new recipients to ensure orientation with emphasis on access to care, choice of PCP, and availability of an initial health risk screening occurs proactively with each recipient who becomes enrolled. If a screening risk level determines need for further care management, a care management referral will be completed.	Section 4 Report 6B Network Adequacy Report 3Q2017.pdf Section 4 Report 6B Network Adequacy Report 4Q2017.pdf PP Access to Care Standards.pdf NVNV_MemberManual 2017.pdf – pg 35 **Description of Process:** Anthem ensures adequate physical and geographical access to covered services for members. Anthem creates quarterly geo access reports to evaluate access and availability including working with DHCFP to determine provider specialty ratios. Anthem assures that members have access to appropriate health screenings, reproductive care, and immunizations from county and state public health clinics. Anthem partners with the Nevada Immunization Coalition to assist members in getting their immunizations and coordinate community health fairs. Anthem conducts welcome calls to all new enrollees where we receive a working phone number from the State. Questions are included to determine if additional care and services are required. Referrals are made to the appropriate	

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		disease or case management areas for further assessment and services.	
	Findings: The document, 2016 NV AGP QM UM Program Evaluation, included an appointment availability analysis to determine if appointment standards were met and to assure access to healthcare and preventive screenings. The policy, Access to Care Standards, described Anthem's ongoing monitoring of the network, which included conducting office site visits and surveys to monitor compliance with appointment wait-time standards and providing an annual evaluation of access and availability of network services to the DHCFP. The Geo Access Reports for the third and fourth quarters of 2017 provided evidence of the MCO's quarterly network monitoring of the geographic location of providers in relation to the enrolled members. The policy, Access to Care Standards, also outlined the provision that Anthem would mandate corrective action for providers that failed to comply with the standards. The policy, PCP Selection, described Anthem's policy to allow members freedom of choice of in-network PCPs and to assign a PCP if a member does not select a PCP within five business days. The policy described the mechanisms for a member to notify Anthem of his/her selection of a PCP. The policy, Member Services' Functions, detailed the process for member services staff members to call to verify each member's PCP or assist with the selection of a new PCP. Anthem staff members confirmed that the MCO works with the following community service providers: Mexican Consulate, REACH, Easter Seals, Boys and Girls Club, Women Infants and Children (WIC) partners, Babies Bounty, and Immunize Nevada.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.6 (A)	14. PCP-to-Recipient Ratios The MCO must have at least one full-time equivalent (FTE) primary care provider, considering all lines of business for that provider, for every 1,500 recipients per service area. However, if the PCP practices in conjunction with a health care professional the ratio is increased to one FTE PCP for every 1,800 recipients per service area.	**Documents Submitted:** PP Access to Care Standards.pdf Section 4 Report 6B Network Adequacy Report 3Q2017.pdf Section 4 Report 6B Network Adequacy Report 4Q2017.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 PP Provider Availability.pdf Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf **Description of Process:** Anthem maintains the PCP ratios required per our contract with DHCFP. Please see the Network Adequacy reports and Geo Access reports that were submitted to DHCFP.	
	Findings: The policy, Provider Availability, detailed Anthem's policy to have at least one full time equivalent (FTE) primary care provider for every 1,500 members per service area. The Geo Access Reports, Section 4 Report 6A Hospital Adequacy reports, and Section 4 Report 6B Network Adequacy reports provided evidence that the MCO produced network monitoring reports that demonstrate the capacity to serve enrolled members.		
	Recommendations: None.		
42 CFR §438.114(c)(1)(i) *DHCFP Contract Section 3.7.5.7 (A)*	15. Access to Emergency Services Emergency Services are provided immediately on a twenty-four (24)-hour basis, seven (7) days a week, with unrestricted access, to enrolled recipients who present at any qualified provider, whether a network provider or an out-of-network provider.	**Documents Submitted:** PP Behavioral Health Emergency Care.pdf PP Access to Care Standards.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		NVNV_ProviderManual 2017.pdf – pgs 14, 65, 71, 73 NVNV_MemberManual 2017.pdf – pgs 35-36 NVNV_CAID_ProviderDirectory_North.pdf NVNV_CAID_ProviderDirectory_South.pdf **Description of Process:** In accordance with the Anthem contract with DHCFP, Anthem members have access to emergency services 24 hours a day, 7 days a week regardless of the provider's network affiliation.	
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to provide emergency coverage twenty-four hours per day, seven days per week with any qualified provider whether the provider is in-network or out-of-network. The Anthem Provider Manual and Anthem Member Manual also contained the provisions for emergency coverage, which were consistent with this element.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.7 (B)	16. PCP Appointments PCP appointments are available as follows: a) Medically necessary, primary care provider appointments are available within two (2) calendar days; b) Same day, urgent care PCP appointments; and	**Documents Submitted:** NVNV_ProviderManual 2017.pdf – pgs 68-69 NVNV_MemberManual 2017.pdf – pgs 8-9 PP Access to Care Standards.pdf Appointment Availability and After-Hours Access fax blast ANVPEC-0419-17.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	c) Routine care PCP appointments are available within two weeks. The two-week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two weeks.	2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 NVNV_CAID_ProviderDirectory_North.pdf NVNV_CAID_ProviderDirectory_South.pdf **Description of Process:** Anthem informs members and providers about the requirements for PCP appointments in the member handbook and the provider manual. Provider Relations routinely monitors compliance with these standards and reports the results to the Quality Management Committee (QMC) via the AGP QM UM Program Evaluation, Appointment Availability Analysis which includes reviewing annual CAHPS survey results, annual appointment and availability survey, complaints and secret shopper call info.	
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to provide PCP appointments in timeframes consistent with the standards outlined in this element. The Anthem Member Manual and Anthem Provider Manual also detailed the appointment availability timeframes for PCP appointments, which were consistent with standards outlined in this element.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.7 (C)(1-4)	17. Specialist Appointments For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide: a) Same day, emergency appointments within twenty-four (24) hours of referral; b) Urgent appointments within three calendar days of referral; and c) Routine appointments within 30 calendar days of referral. The MCO must allow access to a child/adolescent specialist if requested by the parents.	**Documents Submitted:** NVNV_ProviderManual 2017.pdf – pg 75 NVNV_MemberManual 2017.pdf – pg 9 PP Access to Care Standards.pdf Appointment Availability and After-Hours Access fax blast ANVPEC-0419-17.pdf 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 NVNV_CAID_ProviderDirectory_North.pdf NVNV_CAID_ProviderDirectory_South.pdf **Description of Process:** Anthem informs members and providers about the requirements for specialist appointments in the member handbook and the provider manual. Provider Relations routinely monitors compliance with these standards and reports the results to the Quality Management Committee (QMC) via the AGP QM UM Program Evaluation, Appointment Availability Analysis which includes reviewing annual CAHPS survey results, annual appointment and availability survey, complaints and secret shopper call info.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to provide specialty care appointments in the timeframes consistent with the standards outlined in this element. The Anthem Member Manual and Anthem Provider Manual also detailed the appointment availability timeframes for specialty care appointments, which were consistent with standards outlined in this element.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.7 (D)(1-4)	18. Prenatal Care Appointments Initial prenatal care appointments shall be provided for enrolled pregnant recipients as follows: a) First trimester within seven calendar days of the first request; b) Second trimester within seven calendar days of the first request; c) Third trimester within three calendar days of the first request; and d) High-risk pregnancies within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.	NVNV_ProviderManual 2017.pdf – pg 75 NVNV_MemberManual 2017.pdf – pg 9 PP Access to Care Standards.pdf Appointment Availability and After-Hours Access fax blast ANVPEC-0419-17.pdf 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 NVNV_CAID_ProviderDirectory_North.pdf NVNV_CAID_ProviderDirectory_South.pdf **Description of Process:** Anthem informs members and providers about the requirements for prenatal appointments in the member handbook and the provider manual. Provider Relations routinely monitors compliance with these standards and reports the results to the Quality Management Committee (QMC) via the AGP QM UM	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Program Evaluation, Appointment Availability Analysis which includes reviewing annual CAHPS survey results, annual appointment and availability survey, complaints and secret shopper call information.	
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to provide prenatal care appointments in the timeframes consistent with the standards outlined in this element. The Anthem Member Manual and Anthem Provider Manual also detailed the appointment availability timeframes for prenatal care appointments, which were consistent with standards outlined in this element.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.8 (A)	19. Appointment Standards The MCO has written policies and procedures disseminating its appointment standards to all network providers, and must assign a specific staff member of its organization to ensure compliance with these standards by the network.	**Documents Submitted:** NVNV_ProviderManual 2017.pdf – pg 75 PP Access to Care Standards.pdf Appointment Availability and After-Hours Access fax blast ANVPEC-0419-17.pdf 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 NVPEC-1046-17 NV Prov Orientation Pres FINAL.pdf **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Anthem disseminates appointment information to providers through the Provider Manual. The Nevada Provider Relations Representative, under supervision of the Provider Relations Manager, reviews this requirement when performing outreach to offices to ensure compliance of these standards by the network. Appointment standards are part of the provider orientation process and ongoing education with practices. Provider Relations routinely monitors compliance with these standards and reports the results to the Quality Management Committee (QMC) via the AGP QM UM Program Evaluation, Appointment Availability Analysis which includes reviewing annual CAHPS survey results, annual appointment and availability survey, complaints and secret shopper call information.	
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to disseminate appointment accessibility and availability standards to providers through the Anthem Provider Manual. The Anthem Provider Manual provided evidence that the MCO outlined the contractually required appointment availability standards in the Anthem Provider Manual. Anthem staff members confirmed that a discussion of the appointment availability standards was part of the provider orientation process.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.8 (B)	20. Monitoring Appointment Standards Concerning the education of its provider network regarding appointment time requirements the MCO shall: a) Monitor the adequacy of its appointment process and compliance; and b) Implement a POC when appointment standards are not met.	**Documents Submitted:** 2016 NV AGP QM UM Program - Evaluation.pdf - Appointment Availability Analysis pg 32-43 PP Access to Care Standards.pdf NVPEC-0874-16 Appointment Availability Script .pdf PEC-ALL-0421-11 Practitioner Office Site Evaluation form.pdf **Description of Process:** Anthem routinely monitors compliance with these standards and reports the results to the Quality Management Committee (QMC) via the AGP QM UM Program Evaluation, Appointment Availability Analysis which includes reviewing annual CAHPS survey results, annual appointment and availability survey, complaints and secret shopper call information.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, Access to Care Standards, outlined the MCO's policy to disseminate appointment accessibility and availability standards to providers through the Anthem Provider Manual and monitor the network to those standards. The policy also described Anthem's ongoing monitoring of the network, which included conducting office site visits and surveys to monitor compliance with appointment wait-time standards and providing an annual evaluation of access and availability of		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	network services to the DHCFP. The policy also outlined the provision that Anthem would mandate corrective action for providers that failed to comply with the standards.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.9	21. Office Waiting Times The MCO shall establish written guidelines that a recipient's waiting time at the PCP's or specialist's office is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Providers are allowed to be delayed in meeting scheduled appointment times when they "work in" urgent cases, when a serious problem is found, or when the patient has an unknown need that requires more services or education than was described at the time the appointment was scheduled.	**Documents Submitted:** 2017 Amerigroup Nevada Appointment Availability Report.pdf NVNV_ProviderManual 2017.pdf – pg 74-75 PP Access to Care Standards.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf Secret Shopper Call list Q3 2017.xlsx **Description of Process:** Anthem has written policies that indicate the required office wait times for network providers. Information on the policy is relayed to providers through the provider manual. Provider relations representatives audit providers with respect to office wait times and Anthem has provided responses to those audits.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, Access to Care Standards, provided evidence of the MCO's written guidelines for office waiting times at PCP or specialist's offices. The Anthem Provider Manual also contained the guidelines for office waiting times.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		
DHCFP Contract Section 3.7.5.13	22. Prohibited Practices The MCO shall take affirmative action so that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated.	**Documents Submitted:** PP Non-Discrimination in Marketing.pdf NVNV_ProviderManual 2017.pdf – pg 15-16 NVNV_MemberManual 2017.pdf – pg 67 Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf **Description of Process:** Anthem does not discriminate against members with respect to race, national origin, creed, color, gender, sexual preference, religion, age, health status, and physical or mental disability. Anthem disseminates this policy to members and providers through the Member Handbook and the Provider Manual. Providers contracted with Anthem are required to abide by the same standards and practices.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Anthem Provider Manual, Anthem Member Manual, and provider agreements detailed the MCO's affirmative action against prohibited practices as outlined in this element.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.6.1	23. Provider Contracts The MCO executes and maintains, for the term of the contract, written provider agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified providers to provide enrolled recipients with all medically necessary covered services.	**Documents Submitted:** Single Case Agreement Template.pdf EyeQuest Provider Contract.pdf Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf PP Access to Care Standards.pdf **Description of Process:** Anthem creates and reviews quarterly geo access reports to evaluate physical and geographic access to determine if there are any areas where additional providers are needed within the network. For providers participating in the Anthem network, Anthem executes and maintains participating provider agreements. Single case agreements are executed when care is required from non-participating providers. However, in emergency situations and for invisible providers (ex: anesthesiologist charges for an authorized out of network transplant), there may not be agreements in	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		place, but information is used from authorizations received from providers.	
	Findings: The Ancillary Provider Agreement 0717, Facility Provider Agreement 0717, and Physician AHP Provider Agreement 0717 provided evidence that Anthem executed written agreements with network providers. The quarterly access reports demonstrated that Anthem monitored provider accessibility standards for the provider network. The list of credentialed and recredentialed providers for the review period also provided evidence that Anthem credentialed new providers and recredentialed existing providers as required by the contract.		
	Recommendations: None.		
DHCFP Contract Section 3.7.6.5	24. Monitoring Providers The MCO must also have written policies and procedures for monitoring its providers, and complete this monitoring on its providers, and for disciplining providers who are found to be out of compliance with the MCO's medical management standards.	**Documents Submitted:** PP Over Under Utilization of Services.pdf **Description of Process:** Anthem monitors over and underutilization of services using reports made available to: Healthcare Management Services (HCMS), Quality Management (QM), Health Promotion (HP) Departments and Corporate Investigations Department (CID). It is also monitored through the health plan grievance process. The results of the reviews are reported to the Medical Advisory Committee (MAC) and the Quality Management Committee (QMC), and are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		The provider relations department, in collaboration with the medical director, develop action plans with providers who are found to be out of compliance with the requirements. Providers are then monitored for six months to determine compliance with the action plan interventions.	
	Findings: The policy, Access to Care Standards, outlined the mechanisms used to monitor provider compliance with access standards, which included the use of quarterly Geo Access Reports, annual after-hours appointment access surveys, and an annual CAHPS survey as well as a review of complaints, grievances, and office site visits. The quality management program description also outlined procedures for monitoring providers and mandating corrective action for providers who fail to comply with medical management standards.		
	Recommendations: None.		
DHCFP Contract Section 3.10.16.7 (A-B)	25. Steps to Assure Accessibility of Services The MCO must take steps to promote accessibility of services offered to recipients. These steps include: a) The points of access to primary care, specialty care and hospital services are identified for recipients; b) At a minimum, recipients are given information about: i. How to obtain services during regular hours of operations; ii. How to obtain emergency and after-hour care;	**Documents Submitted:** NVNV_CAID_ProviderDirectory_North.pdf NVNV_CAID_ProviderDirectory_South.pdf NVNV_MemberManual 2017.pdf – pgs 8-9, 36-37 NVNV_ProviderManual 2017.pdf – pgs 14, 65, 68-69, 73, 75 **Description of Process:** Anthem informs members about how to obtain care during regular hours, after hours, in emergencies, and outside of the service	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	iii. How to obtain emergency out-of-service area care; iv. How to obtain the names, qualifications and titles of the professionals who provide and are accepting medical patients and/or are responsible for their care; and v. How to access concierge services and if needed case management assistance from the vendor when needed to gain access to care.	area through the Member Handbook. Anthem provides members with information about provider qualifications and specialties through the provider directories and the provider search function on the Anthem web portal.	
	Findings: The Anthem Member Manual contained information concerning the role of the PCP in providing and directing the care of members. The Anthem Member Manual also provided examples of routine, urgent, and emergency care and explained how members can access care. In an emergency situation, members are advised to go to the nearest hospital emergency room. The provider directory included information concerning the providers included in the Anthem network, and the handbook contained the link to the automated provider directory. The member services department and the after-hours nurse call center also provide assistance to members who requested information about accessing services.		
	Recommendations: None.		
DHCFP Contract Section 3.10.17	26. Standards for Availability and Accessibility The MCO must: a) Establish standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice and recipient service lines) and complies with this RFP. b) Assess performance on these dimensions of access against the established standards.	**Documents Submitted:** 2016 NV AGP QM UM Program Evaluation.pdf - Appointment Availability Analysis pg 32-43 2017 Amerigroup Nevada Appointment Availability Report.pdf NVNV_ProviderManual 2017.pdf – pgs 68-69, 75 NVNV_MemberManual 2017.pdf – pgs 8-9	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		PP Access to Care Standards.pdf Appointment Availability and After-Hours Access fax blast ANVPEC-0419-17.pdf **Description of Process:** Information on the access standards is relayed to providers through the provider manual, to members through the member handbook, and annually through network wide fax blast to remind providers of the standards. Provider relations representatives audit providers with respect to access.	
	Findings: The policy, Access to Care Standards, outlined the activities used to monitor provider compliance with access standards. The policy also described the use of several mechanisms to monitor compliance against the established standards, including quarterly Geo Access Reports, annual after-hours and appointment access surveys, and an annual CAHPS survey as well as a review of complaints, grievances, and office site visits. The Anthem Provider Manual and the provider agreements contained access standards for routine, urgent, and emergency care. Interviews with staff members confirmed that Anthem monitored standards concerning access to care, including call center standards, and developed corrective action plans when the standards were not achieved by the MCO, the nurse call center, or the providers.		
	Recommendations: None.		

Results for Standard II: Availability and Accessibility of Services							
Total	Met	=	25	X	1.00	=	25.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	1	X	.00	=	0.0
	Not Applicable	=	0	X	.00	=	0.0
	Total Applicable	=	26	**Total Rate**		=	25.0
Total Rate ÷ Total Applicable = Total Score							96.2%

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.4.1	1. Subcontractors All Subcontracts, including delegation agreements, are in writing, are prior approved by the DHCFP, and contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract, as amended.	**Documents Submitted:** Ancillary Provider Agreement 0717.pdf Eyequest Provider Contract.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf 170601 NV Visions Agreement.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** Anthem maintains subcontracts and delegation agreements in writing. Templates of these agreements are provided to support this requirement. The agreements are provided and approved by DHCFP if the contract meets criteria for such filing. The Anthem Regulatory Manager submits these contracts to DHCFP. Approvals of such are retained within the Regulatory Department.	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
	Findings: The Delegate/Vendor Oversight & Management Program Description and Delegate/Vendor Oversight and Management Program policy included statements that the Delegate/Vendor Oversight & Management ensures written agreements with each delegate clearly define and describe the delegated activities, responsibilities, and reporting requirements for both the MCO and the proposed delegate. Anthem provided agreements for eight subcontractors, but there		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	was no evidence submitted during the desk review or after the onsite review, as requested, to support approval was obtained from DHCFP prior to implementing the delegated subcontracts.		
	Recommendations: Anthem must ensure all delegated agreements are approved by the DHCFP prior to implementation and contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract.		
42 CFR §438.6(i)(1) *42 CFR §423.208* *42 CFR §422.210* *DHCFP Contract Section 3.7.6.6*	2. Physician Incentive Plan If the MCO has a physician incentive plan, it must comply with section 1876 of the Social Security Act and the reporting requirements outlined in 42 CFR §423.208 and §422.210, pursuant to 42 CFR §438.6(i)(1).	**Documents Submitted:** Eyequest Provider Manual.pdf NVNV_ProviderManual 2017.pdf NVNV_MemberManual 2017.pdf NVPEC-1131-17 PQIP Intro PPT 2018 FINAL.pdf PP Financial Incentives.pdf **Description of Process:** Anthem supports the requirements of the Social Security Act in accordance with Physician Incentive requirements. The documents provided indicated that members are informed and offered information regarding provider payment process and indicates to providers that incentives are not issued for authorization denials or other determinations.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: Anthem provided its Provider Quality Incentive Program (PQIP) document that was directed towards providers. The PQIP included information about value-based payment, support for patient-centered care, and provider reporting and		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	analytics. Participation requirements for the PQIP were included. During the onsite review, Anthem provided confirmation that this physician incentive plan has been in place for years and was pre-approved by the State.		
	Recommendations: None.		
42 CFR §438.214 *42 CFR §438.6* *DHCFP Contract Section 3.15.4.1*	3. Subcontracts with Health Care Professionals The MCO complies with the requirements in 42 CFR §438.214 regarding contracts with health care professionals. The MCO ensures that all subcontracts fulfill the requirements of 42 CFR §438.6 that are appropriate to the service or activity delegated under the subcontract.	**Documents Submitted:** NV Uniform Credentialing Application_Required NDOI-901 (Anthem Core).pdf NV Uniform Credentialing Application_Required NDOI-901.pdf Policy 1 Credentialing Program Structure V.3 (Anthem Core).pdf Policy 2 CR Program Provider Scope V.5 (Anthem Core).pdf Policy 4.0.1 BH Nonphysician Ed Criteria V.3 (Anthem Core).pdf Policy 4.0.2 Cred of NPs Cert Nurse Midwives_Pas V.5 (Anthem Core).pdf Policy 4.1 Pro Comp Conduct Criteria Hlth Delv Orgs V.6 (A Core).pdf Policy 5 Initial Application V.3 (Anthem Core).pdf Policy 6 Process of Verification of Data Elements V.2 (Anthem Core).pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Policy 6.1 Dist of App Info Related Pract Ed Train Cert V.2 (Anthem Core).pdf Policy 9 Re-credentialing V.4 (Anthem Core).pdf Eyequest Provider Contract.pdf 170601 NV Vision Agreement.pdf 7.20.2017 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** All providers seeking to contract with Anthem and/or to obtain delegation status are reviewed through the standard credentialing and recredentialing processes as noted in the supporting documents. If a provider or group becomes delegated for any appropriate function, these providers or groups must participate in a pre-delegation assessment and approved by the Credentials Committee. Ongoing monitoring and reporting is performed to address any necessary corrective actions required by the delegate.	

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Anthem retains ultimate accountability for any functions delegated to a provider or group or applicable entity.	
	Findings: Anthem's credentialing program complied with the provider selection requirements found in 42 CFR §438.214.		
	Recommendations: None.		
42 CFR §438.12(a)(2) *DHCFP Contract Section 3.15.4.2*	4. MCO Oversight Requirements The MCO is responsible for oversight of all network subcontracts and is accountable for any responsibilities it delegates to any subcontracted provider (AKA, subcontractor). The MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated.	**Documents Submitted:** Minutes DVOMC 7.2017.pdf – providing onsite October 2017 DOC Report.pdf – providing onsite November 2017 DVOMC Report.pdf – providing onsite AUG 2017 DVOMC Report.pdf – providing onsite July 2017 DVOMC Delegated Cred Report.pdf – providing onsite September 2017 DVOMC Del Cred Report.pdf – providing onsite AUG 2017 DVOMC Del Cred Report.pdf – providing onsite 7.20.2017 APPROVED Program Description.pdf 11.09.2017 APPROVED GBP Policy Procedure.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: All providers seeking delegation or that are currently delegated for any activity are assessed prior to delegation, annually thereafter, and through reporting activities. The predelegation audit is performed to determine the ability of the provider to perform the necessary delegated function. Once actions are addressed, the delegate is presented through the Credentials Committee for delegation approval. Annually, the delegate's performance is assessed and corrective actions are taken where appropriate. On an established basis, the delegate is required to report to Anthem performance measures based on contractual standards at minimum monthly to address any potential actions based on nonperformance.	
	Findings: The Delegate/Vendor Oversight & Management Program Description and policy included the provision that the MCO is accountable for any responsibilities it delegates to any subcontracted provider. Additionally, the program description detailed the mechanism the MCO uses to evaluate prospector subcontractors. During the onsite review, Anthem provided copies of completed audits tools, which supported that the MCO evaluates its delegates against program requirements and other criteria to confirm the delegates have the ability to perform the delegated activities.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.3	5. Prior-Approval Requirements by DHCFP All subcontracts for administrative services provided pursuant to this Request For Proposal (RFP), including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, are prior- approved by DHCFP.	**Documents Submitted:** Eyequest Provider Contract.pdf 170601 NV Visions Agreement.pdf 7.20.17 APPROVED Program Description.pdf 11/09/2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** Various Anthem departments in conjunction with the Legal Department negotiate contracts with vendors. The negotiated contracts are submitted to DHCFP by the Regulatory Services Department for review and approval.	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
	Findings: The Delegate Terminations and De-Delegations policy and procedure indicated certain administrative functions may require the submission of the agreement to the State for approval prior to implementation. During the onsite review, HSAG reviewers requested that Anthem provide evidence to support all prospective delegates were approved by DHCFP prior to implementation. Anthem did not provide evidence that DHCFP approved the delegated entities.		
	Recommendations: Anthem must ensure all delegated entities providing administrative services are approved by DHCFP prior to implementation.		
DHCFP Contract Section 3.15.4.3	6. Disclosing MCO Ownership in the Subcontracted Entity Prior to the award of any subcontract or execution of an agreement with a delegated entity, the MCO provides written information to the DHCFP disclosing	**Documents Submitted:** PP Disclosure of Change in Ownership or Controlling.pdf 7.20.17 APPROVED Program Description.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	the MCO's ownership interest of 5 percent or more in the subcontractor or delegated entity, if applicable. All subcontracts are submitted to DHCFP for approval prior to their effective date. Failure to obtain advance written approval of a subcontract from DHCFP results in the application of a penalty of $25,000 for each incident.	11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** To the best of our information, knowledge, and belief, Anthem has not had a 5% ownership interest in any of the subcontracting entities for which we have submitted subcontracts for DHCFP's review and approval. Should Anthem have a 5% ownership in a subcontracted entity or should Anthem obtain such ownership, DHCFP will be notified accordingly.	
	Findings: The State Notification—Disclosure of Change in Ownership or Controlling Interest policy described Anthem's regulatory and State contractual obligations regarding any changes in ownership or controlling interest. Additionally, this policy included language to support that Anthem notifies State agencies of any person with an ownership or controlling interest of five percent or more.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.4	7. Subcontractors By the service start date and whenever a change occurs, submit to DHCFP for review and approval the names of any material subcontractors the MCO has hired to perform any of the requirements of the Contract and the names of their principals.	**Documents Submitted:** 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf PP Disclosure of Change in Ownership or Controlling.pdf	☐ Met ☐ Partially Met ☒ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		PP Subcontractors Disclosure of Ownership.pdf **Description of Process:** Whenever a change occurs, Anthem notifies DHCFP of these changes.	
	Findings: The Delegate/Vendor Oversight & Management Program Description and policy did not include the requirement that the MCO must obtain approval from DHCFP prior to service start date and whenever there was a change in subcontractors. During the onsite review, Anthem provided the Delegate Terminations and De-delegations policy and procedure, which specified certain functions required the submission of the agreement to the State for approval prior to implementation. Although HSAG reviewers requested evidence to support that the delegated agreements were submitted to DHCFP for approval, Anthem did not provide documentation to support DHCFP reviewed and approved material subcontractors, or delegates, hired to perform requirements of the contract as indicated.		
	Recommendations: By the service start date and whenever a change occurs, Anthem must submit to DHCFP for review and approval the names of any material subcontractors hired to perform any of the requirements of the Contract and the names of their principals.		
DHCFP Contract Section 3.15.4.5	8. Subcontract Requirements a) The MCO maintains all agreements and subcontracts relating to the contract in writing. b) The MCO provides copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request. c) The MCO's agreements and subcontracts contain relevant provisions of the contract appropriate to the subcontracted service or activity, specifically including but not limited to	**Documents Submitted:** Eyequest Provider Contract.pdf 170601 NV Visions Agreement.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	the provisions related to confidentiality, HIPAA requirements, insurance requirements and record retention. d) The MCO has the responsibility to assure that subcontractors are adequately insured to current insurance industry standards.	**Description of Process:** As indicated in the contracts, Anthem maintains copies of agreements with subcontractors. Should DHCFP request it, the plan provides a copy of the contract requested within the required timeframe. Anthem's contracts with providers in Section 6.16(b) require providers to comply with all relevant provisions of the Medicaid ProgYEs,ram Contract appropriate to the Provider's service or activity, specifically including provisions related to confidentiality, federal HIPAA requirements, insurance requirements and record retention. This requirement is included in all delegation agreements.	
	Findings: Anthem provided copies of its delegation agreements, which demonstrated the agreements are in writing and contain relevant provisions of the contract appropriate to the subcontracted service. During the onsite review, Anthem also confirmed it would provide copies of agreements to DHCFP within five days of receiving such a request.		
	Recommendations: None.		
42 CFR §438.230(b)(1) *DHCFP Contract Section 3.15.4.6*	9. Responsibility of MCO The MCO remains fully responsible for meeting all of the requirements of the Contract regardless of any subcontracts for the performance of any Contract	**Documents Submitted:** Eyequest Provider Contract.pdf 170601 NV Visions Agreement.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	responsibility. No subcontract operates to relieve the MCO of its legal responsibility under the Contract.	Physician-AHP Provider Agreement 0717.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** As indicated in the agreements with subcontractors, Anthem is fully responsible for meeting the requirements of its contract with DHCFP.	
	Findings: The Delegate/Vendor Oversight & Management Program Description contained a statement that Anthem is accountable for all functions performed by delegates and ensures delegated functions are completed in accordance with contractual and applicable federal, State, and accreditation standards.		
	Recommendations: None.		
42 CFR §438.230(c)(1)(i) *DHCFP Contract Section 3.15.4.7*	10. Written Agreements The MCO must have a written agreement with the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate or substandard.	**Documents Submitted:** Eyequest Provider Contract.pdf 170601 NV Visions Agreement.pdf Ancillary Provider Agreement 0717.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: Amerigroup maintains written agreements with subcontractors that specify the activities and report responsibilities delegated to the subcontractor and provide for revoking delegation or put the provider on corrective action if the subcontractor's performance is inadequate or substandard.	
	Findings: Anthem's written agreements with its delegates specified the delegated activities and report responsibilities and included language that provides for revoking delegation or imposing sanctions for inadequate performance.		
	Recommendations: None.		
42 CFR §438.230(a)(1) *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)(iii)* *DHCFP Contract Section 3.15.4.8*	11. Monitoring Performance of the Subcontractor The MCO must monitor the subcontractor's performance on an on-going basis and subject the subcontractor to formal review according to periodic schedules established by the State, consistent with industry standards and/or State laws and regulations. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor must take corrective action.	**Documents Submitted:** AUG 2017 DVOMC Del Cred Report.pdf – providing onsite AUG 2017 DVOMC Report.pdf – providing onsite July 2017 DVOMC Delegated Cred Report.pdf – providing onsite Minutes DVOMC 7.2017.pdf – providing onsite November 2017 DVOMC Report.pdf – providing onsite	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		October 2017 DOC Report.pdf – providing onsite PEC-ALL-0421-11 Practitioner Office Site Evaluation Form.pdf September 2017 DVOMC Report.pdf – providing onsite V600.006 – Quarterly Appointment Surveys.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** Each subcontractor receives a comprehensive Annual Audit of all delegated services and/or administrative functions performed on Amerigroup's behalf. Quarterly Joint Operations Meetings are conducted to review the delegate's contractual compliance, report submission, and Quality Oversight Review with the Health Plan Associates and Representatives from the Health Plan. This requirement is also included in all delegation agreements.	

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: During the onsite review, Anthem staff members stated that all delegates were audited annually or more frequently when a need for additional review is identified. Minutes from the Delegation Operations Committee Meeting confirmed corrective action plans were implemented when deficiencies were identified, and these corrective action plans were monitored regularly.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.9	12. Termination of Subcontract The MCO notifies DHCFP, in writing, immediately upon notifying any material subcontractor of the MCO's intention to terminate any such subcontract.	**Documents Submitted:** Policy 18.1 Revocation of Delegation Agreements.pdf Policy 10 Termination and Immediate Termination V.2 (Anthem Core).pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** If Anthem intends to terminate a material subcontracted vendor, we will notify DHCFP in accordance with current requirements as outlined in our contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Delegate Terminations and De-Delegations policy and procedure stipulated notification of terminations/de-delegations will be sent to the appropriate State agencies as required by the contract or regulation and includes the reason for the termination and the transition/contingency plan. During the onsite review, Anthem staff members clearly described the termination process, including the steps for ensuring continuity of care and services.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.10	13. Ownership of Subcontractor Within 35 calendar days of the date of request, the MCO must provide full and complete information about the ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of request as required by 42 CFR §455.105. Failure to timely comply with the request results in withholding of payment by the State to the MCO. Payment for services cease on the day following the date the information is due and begin again on the day after the date on which the information is received.	**Documents Submitted:** PP Disclosure of Change in Ownership or Controlling.pdf PP Subcontractors Disclosure of Ownership.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** Anthem monitors and tracks disclosures of ownerships and reports findings to DHCFP.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Medicaid Subcontractors Disclosure of Ownership policy included the requirements of this element.		
	Recommendations: None.		

Results for Standard III: Subcontracts and Delegation						
Total	Met	= 10	10 X	1.00	=	10.0
	Partially Met	= 1	1 X	.50	=	0.5
	Not Met	= 2	2 X	.00	=	0.0
	Not Applicable	= 0	0 X	.00	=	0.0
	Total Applicable	= 13	**Total Rate**		=	10.5
Total Rate ÷ Total Applicable			= **Total Score**			80.8%

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.24	1. Dispute Resolution The MCO must adequately staff a provider services unit to handle provider questions and disputes.	**Documents Submitted:** NVPEC-1046-17 NV Prov Orientation Pres.pdf IRU Oversight and Support Strategy.pdf PP Provider Payment Appeal Process.pdf NVNV_ProviderManual 2017.pdf - pgs 113-114 Provider Contact Reference Sheet – 2017 NVPEC-1000-17.pdf PP NCC Provider Service Functions.pdf **Description of Process:** Anthem has defined a Provider Dispute in relation to a claims payment issue. Therefore, the documentation submitted to meet the requirements in this section speaks to how we resolve provider payment disputes/appeals. Anthem has a formal provider dispute unit that receives written disputes/appeals. Anthem also has a National Customer Call Center (NCC) that provides telephonic assistance to providers regarding a wide range of services that include provider disputes/appeals. In addition, Anthem has a local health plan Provider	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Relations team that can field issues via phone, email or in person.	
	Findings: The policy, Provider Payment Appeal Process, outlined the MCO's procedures for processing provider claims disputes and the role of the claims department to process and resolve the disputes. The policy, Provider Grievance Process, outlined the MCO's procedures for processing provider-level grievances and the role of the provider services unit to resolve provider grievances. The Anthem organizational chart and provider services unit organizational chart provided evidence that the MCO adequately staffed the provider services unit to handle inquiries and disputes from providers. Anthem staff members stated that provider inquires can be handled by any unit at Anthem, including the national call center, internal resolution unit, as well as the provider services unit. Anthem staff members stated that all inquiries and disputes are logged in the provider engagement grievances and appeals (PEGA) system and is routed to the proper unit to handle the inquiry, such as the claims processing unit if there is an inquiry related to a claim. Anthem staff members stated that all contact with providers, including those contacts to resolve a claims dispute, are tracked in SalesForce. That allows other staff members to query the information and communication that has already taken place with the provider so that staff members may process the inquiry or dispute to resolution. The internal resolution unit (IRU) will review trends regularly to identify issues that may be systemic versus those issues that are unique to a single provider or set of providers. Anthem staff members stated that this review is necessary to determine if changes can be made at the MCO-level that will alleviate burdens for providers or enable claims to be processed more smoothly.		
	Recommendations: None.		
DHCFP Contract Section 3.10.24.1	2. Resolving Disputes The MCO must resolve 90% of written, telephone or personal contacts within 90 calendar days of the date of receipt with appropriate follow up to provider.	**Documents Submitted:** AGP Q1 2018 Report 5 Provider Dispute Reporting Form (Q3 2017 data).xlsx AGP Q2 2018 Report 5 Provider Dispute Reporting Form (Q4 2017 data).xlsx PP Provider Payment Appeal Process.pdf PP Provider Grievances Process.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		PP Administrative Denial Appeal Process.pdf **Description of Process:** The reports submitted to support this section are related to provider disputes, inclusive of claims payment issues. The attached reports indicate that at least 90% of provider disputes were resolved within 30 calendar days.	
	Findings: The policy, Provider Payment Appeals Process, detailed Anthem's policy to resolve disputes and communicate the decision to providers within 30 calendar days. Anthem staff members stated that all inquiries and disputes are logged in the PEGA system and routed to the proper unit to handle the inquiry, such as the claims processing unit if there is an inquiry related to a claim. Staff members stated that they generate reports from PEGA to monitor the resolution of provider disputes. The system demonstration showed that 93 percent of disputes were resolved within 30 days.		
	Recommendations: None.		
DHCFP Contract Section 3.10.24.2	3. Log of Provider Disputes A written record in the form of a file or log is maintained by the MCO for each provider dispute to include the nature of it, the date filed, dates and nature of actions taken, and final resolution.	**Documents Submitted:** AGP Q1 2018 Report 5 Provider Dispute Reporting Form (Q3 2017 data).xlsx AGP Q2 2018 Report 5 Provider Dispute Reporting Form (Q4 2017 data).xlsx NV Provider Call Purpose 07.17.17-12.31.17.xlsx PP Customer Inquiry Logs.pdf **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Anthem uses Facets and Macess systems for managing and documenting provider disputes. Data is collected from these two systems to populate required report submissions to DHCFP as well as for internal monitoring and oversight purposes.	
	Findings: Anthem staff members stated that all inquiries and disputes were logged in the PEGA system and routed to the proper unit to handle the inquiry, such as the claims processing unit if there is an inquiry related to a claim. The system demonstration of PEGA showed the written description of the provider dispute/appeal, description of the issue, the date filed, the dates and nature of actions taken, and the final resolution.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8	4. Provider Grievances and Appeals The MCO must establish a process to resolve any provider grievances and appeals that are separate from, and not a party to, grievances and appeals submitted by providers on behalf of recipients. Written Grievance and Appeals procedures must be included, for review and approval, at the time the MCO policies and procedures are submitted to the DHCFP and at anytime thereafter when the MCO's provider grievance and appeals policies and procedures have been revised or updated. The MCO may not implement any policies and procedures concerning its provider grievance and appeal system without first obtaining the written approval of the DHCFP.	**Documents Submitted:** PP Medical Necessity Appeals.pdf PP Provider Payment Appeal Process.pdf PP Provider Grievances Process.pdf PP Administrative Denial Appeal Process.pdf NVNV_ProviderManual 2017.pdf - pgs 111-118 **Description of Process:** Anthem maintains policies to address provider grievances and appeals. Anthem submits the policies to DHCFP annually during the policies and procedures binder submission. Should	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		changes be made to the policies outside the binder submission, Anthem will submit revised policies to DHCFP for their review and approval. EyeQuest also maintains policies to address provider grievances and appeals.	
	Findings: The policy, Provider Payment Appeal Process, outlined the MCO's procedures for processing provider claims/disputes and the role of the claims department to process and resolve the disputes. The policy, Provider Grievance Process, outlined the MCO's procedures for processing provider-level grievances and the role of the provider services unit to resolve provider grievances. Both policies described processes that were separate from the grievance and appeals procedures for members. The letter from April 27, 2017, from Anthem to DHCFP provided evidence that Anthem (operating as Amerigroup at the time) submitted the required policy information to DHCFP for review and approval prior to implementing the policies.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1	5. Accepting Provider Grievances and Appeals When handling Grievances and Appeals: a) The MCO must accept written or oral grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP. b) An oral appeal must be followed by a written, signed appeal; however, the oral appeal must count as the initial date of appeal.	**Documents Submitted:** PP Medical Necessity Appeals.pdf PP Provider Payment Appeal Process.pdf PP Provider Grievances Process.pdf PP Administrative Denial Appeal Process.pdf NVNV_ProviderManual 2017.pdf - pgs 111-118 **Description of Process:** Anthem accepts both written and oral grievances. Appeals (payment disputes) and	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		grievances may be submitted by the provider or DHCFP. An oral appeal must be followed by a written appeal, but Anthem will use the date of the oral appeal as the initial date of appeal.	
	Findings: The policy, Provider Grievances Process, and the policy, Administrative Denial Appeal Process, provided evidence of meeting the processing and disposition requirements of this element. The policies included the provision that Anthem accepted both written and oral grievances and that oral appeals were followed by a written, signed appeal.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1	6. Written Record of Provider Grievances and Appeals The MCO must keep a written or electronic record of each provider grievance and appeal to include a description of the issue, the date filed, the dates and nature of actions taken, and the final resolution.	**Documents Submitted:** PP Medical Necessity Appeals.pdf PP Provider Payment Appeal Process.pdf PP Provider Grievances Process.pdf PP Administrative Denial Appeal Process.pdf NVNV_ProviderManual 2017.pdf - pgs 111-118 Appeal Tracking System screen shot - APP - 315461.pdf AGP Q1 2018 Report 5 Provider Dispute Reporting Form (Q3 2017 data).xlsx AGP Q2 2018 Report 5 Provider Dispute Reporting Form (Q4 2017 data).xlsx Appeals Detail Report 2017.xlsx	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: Provider grievances and appeals are tracked in one of two logs submitted as documentation for this requirement. Provider Disputes are recorded and detailed in the Facets system and filed in Macess.	
	Findings: Anthem staff members stated that all inquiries and disputes were logged in the PEGA system, which is linked to the Facets system, and routed to the proper unit to handle the inquiry, such as the claims processing unit if there is an inquiry related to a claim. The system demonstration of PEGA showed the written description of the provider dispute/appeal, description of the issue, the date filed, the dates and nature of actions taken, and the final resolution.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1(A-B)	7. Timing of Final Decisions The MCO must issue a final decision, in writing, no later than: a) Ninety (90) calendar days after a grievance is filed; and, b) Thirty (30) calendar days after an appeal is filed.	**Documents Submitted:** PP Medical Necessity Appeals.pdf PP Provider Payment Appeal Process.pdf PP Provider Grievances Process.pdf PP Administrative Denial Appeal Process.pdf NVNV_ProviderManual 2017.pdf - pgs 111-118 **Description of Process:** Anthem resolves provider payment disputes (appeals) within 30 calendar days. Anthem resolves provider grievances within 90 days after a grievance is filed.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The policy, Provider Grievances Process, included the provision that grievances would be resolved with a final notice of decision issued to providers within 90 calendar days of receipt of the grievance. The policy, Provider Payment Appeal Process, and the policy, Administrative Denial Appeal Process, contained the provision that the MCO would issue a final decision in writing to the provider within 30 calendar days of receiving the appeal. The system demonstration of PEGA showed the final resolution letter templates that were sent to providers as written notification of resolution.		
	Recommendations: None.		

Results for Standard IV: Provider Dispute and Complaint Resolution							
Total	Met	=	7	X	1.00	=	7.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
	Not Applicable	=	0	X	.00	=	0.0
	Total Applicable	=	7	**Total Rate**		=	7.0
Total Rate ÷ Total Applicable = Total Score							100%

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.8.2	1. Provider Workshops The MCO must conduct, at least annually, provider workshops in the geographic service area to accommodate each provider site. In addition to presenting education and training materials of interest to all providers, the workshops must provide sessions for each discrete class of providers whenever the volume of recent changes in policy or procedures in a provider area warrants such a session. All sessions should reinforce the need for providers to verify recipient eligibility and enrollment prior to rendering services in order to ensure that the recipient is Medicaid-eligible and that claims are submitted to the responsible entity. Individual provider site visits will suffice for the annual training requirement.	**Documents Submitted:** NVPEC-1046-17 NV Prov Orientation Pres FINAL.pdf Monthly Provider Orientation Webinar Invite NVPEC-0263-13.pdf **Description of Process:** Anthem schedules provider workshops online via webinar. During the monthly sessions, Anthem discusses issues relating to verifying member eligibility and enrollment and addresses provider concerns on those topics among others. Anthem also conducts individual provider face to face site visits to provide information on how to verify recipient eligibility and enrollment in addition to any recent changes in policy or procedures and any other topic of interest to the provider. Anthem Provider Relations Department conducts on the average 25 individual provider visits per month for each Provider Relations Representative employed by the Nevada Health Plan in an attempt to reach as many provider office as possible every month.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The policy, Provider Education and Communication, described the types of communications and media made available to providers to educate them on health plan policies and procedures and changes to federal and State requirements. The communication channels described in the policy were: provider website, site visits by provider relations staff, workshops and in-service presentations, broadcast faxing, provider mailings, provider web demonstrations and tutorials, and emails from provider relations staff. The provider orientation presentation provided evidence of the type of presentation given to providers new to the health plan. The document, Monthly Provider Orientation Webinar Invite, served as an invitation to providers to participate in the provider orientation webinars that were offered by Anthem. Anthem staff members stated that provider relations representatives visited high-volume provider offices at least quarterly and they visited all other providers at least annually.		
	Recommendations: None.		
DHCFP Contract Section 3.7.8.3	2. Provider Newsletter The MCO must publish a semi-annual newsletter for network providers. Topics may include practice guidelines, policy updates, quality management strategies, and other topics of provider interest.	**Documents Submitted:** Provider Newsletter 2017 Q3 NV-NL-0076-17.pdf Provider Newsletter 2017 Q4 NV-NL-0089-17.pdf **Description of Process:** Anthem drafts provider newsletters on a quarterly basis. The quarterly newsletters are reviewed via an internal collateral materials review process (CMAP). The approved CMAP documents are submitted to DHCFP for review and approval. Once the document is approved by DHCFP, it is sent to providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The provider newsletters for third and fourth quarter provided evidence that the MCO published newsletters for providers. The policy, Provider Education and Communication, included the provision that newsletters would be produced at least semi-annually; however, Anthem staff members stated that provider newsletters were produced quarterly.		
	Recommendations: None.		
DHCFP Contract Section 3.7.8.4	3. Provider Newsletters on MCO Website The MCO must provide a copy of all newsletters to the DHCFP. Additionally, these newsletters and announcements regarding provider workshops must be published on the MCO's website.	**Documents Submitted:** Provider Newsletter and Training Invitations Posted on Anthem Website: https://mediproviders.anthem.com/nv/pages/communications-updates.aspx https://mediproviders.anthem.com/nv/pages/manuals-directories-training.aspx **Description of Process:** Anthem publishes provider newsletters and announcements regarding provider workshops on the MCO's website	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The link to the Anthem website provided evidence that Anthem provided copies of provider newsletters and announcements for provider workshops and other trainings and toolkits on the provider section of the Anthem website.		
	Recommendations: None.		

Results for Standard V: Provider Information							
Total	Met	=	3	X	1.00	=	3.0
	Partially Met	=	0	X	.50	=	0.0
	Not Met	=	0	X	.00	=	0.0
	Not Applicable	=	0	X	.00	=	0.0
	Total Applicable	=	3	**Total Rate**		=	3.0
Total Rate ÷ Total Applicable = Total Score							100%

Compliance With Standards Review Tool CAP

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.6.3.2	12. Twenty-five (25) Mile Rule The MCO must offer every enrolled recipient a PCP or Primary Care Site located within a reasonable distance from the enrolled recipient's place of residence, but in any event, the PCP or PCS may not be more than twenty-five (25) miles from the enrolled recipient's place of residence per NAC 695C.160 without the written request of the recipient.	**Documents Submitted:** PP PCP Selection Assignment.pdf PP Access to Care Standards.pdf Nevada Geo HSAG Report_3Q17.pdf Nevada Geo HSAG Report_4Q17.pdf **Description of Process:** Anthem offers access to a PCP within 25 miles of a member's home. When a member does not select a PCP, the member is auto-assigned to a PCP that is within 25 miles from the member's home. In those instances where this is not met, it is due to geographical limitations of the county and location of PCP's in that area. In both Clark and Washoe County there are several members that are not within 25 miles. That is because there are no PCP offices located within 25 minutes of these members home, they are very remote residences.	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
	Findings: The policy, Provider Availability, provided evidence of the MCO's policy to ensure that at least one PCP is located within 25 miles of each member's home. The Geo Access Reports provided evidence that the majority of members had at least one PCP within 25 miles of their place of residence. The Geo Access Report from third quarter 2017 showed that there		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	was a total of six members in Laughlin where the closest PCP was 64.3 miles away. Anthem staff members stated that there were no primary care physicians within a 25-mile radius of each member's residence. Anthem staff members confirmed that the MCO did not have written requests from the members to obtain services from a PCP that was greater than 25 miles from each member's residence. A similar finding was found in the SFY 2014–2015 IQAP Compliance Review and HSAG made the following recommendation, "Amerigroup needs to ensure that all members have a PCP that is 25 miles or closer to the member's place of residence unless Amerigroup has a written request from the member to allow assignment to a PCP that is greater than 25 miles from the member's place of residence." It did not appear, through a review of documentation and interviews with staff members, that Anthem had processes in place to seek each member's request to allow assignment to a PCP that is greater than 25 miles from each member's residence.		
	Recommendations: Anthem must ensure that all members have a PCP that is 25 miles or closer to each member's place of residence unless Anthem has a written request from the member to allow assignment to a PCP that is greater than 25 miles from the member's place of residence.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.4.1	1. Subcontractors All Subcontracts, including delegation agreements, are in writing, are prior approved by the DHCFP, and contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract, as amended.	**Documents Submitted:** Ancillary Provider Agreement 0717.pdf Eyequest Provider Contract.pdf Facility Provider Agreement 0717.pdf Physician-AHP Provider Agreement 0717.pdf 170601 NV Visions Agreement.pdf 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** Anthem maintains subcontracts and delegation agreements in writing. Templates of these agreements are provided to support this requirement. The agreements are provided and approved by DHCFP if the contract meets criteria for such filing. The Anthem Regulatory Manager submits these contracts to DHCFP. Approvals of such are retained within the Regulatory Department.	☐ Met ☒ Partially Met ☐ Not Met ☐ NA
	Findings: The Delegate/Vendor Oversight & Management Program Description and policy included statements that the Delegate/Vendor Oversight & Management ensures written agreements with each delegate clearly define and describe the delegated activities, responsibilities, and reporting requirements for both the MCO and the proposed delegate. Anthem		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	provided agreements for eight subcontractors, but there was no evidence submitted during the desk review or after the onsite review, as requested, to support approval was obtained from DHCFP prior to implementing the delegated subcontracts.		
	Recommendations: Anthem must ensure all delegated agreements are approved by the DHCFP prior to implementation and contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.3	5. Prior-Approval Requirements by DHCFP All subcontracts for administrative services provided pursuant to this Request For Proposal (RFP), including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, are prior- approved by DHCFP.	**Documents Submitted:** Eyequest Provider Contract.pdf 170601 NV Visions Agreement.pdf 7.20.17 APPROVED Program Description.pdf 11/09/2017 APPROVED GBD Policy Procedure.pdf **Description of Process:** Various Anthem departments in conjunction with the Legal Department negotiate contracts with vendors. The negotiated contracts are submitted to DHCFP by the Regulatory Services Department for review and approval.	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
	Findings: The Delegate Terminations and De-Delegations policy and procedure indicated certain administrative functions may require the submission of the agreement to the State for approval prior to implementation. During the onsite review, HSAG reviewers requested that Anthem provide evidence to support all prospective delegates were approved by DHCFP prior to implementation. Anthem did not provide evidence that DHCFP approved the delegated entities.		
	Recommendations: Anthem must ensure all delegated entities providing administrative services are approved by DHCFP prior to implementation.		
Corrective Action Plan			

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
(Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.4	7. Subcontractors By the service start date and whenever a change occurs, submit to DHCFP for review and approval the names of any material subcontractors the MCO has hired to perform any of the requirements of the Contract and the names of their principals.	**Documents Submitted:** 7.20.17 APPROVED Program Description.pdf 11.09.2017 APPROVED GBD Policy Procedure.pdf PP Disclosure of Change in Ownership or Controlling.pdf PP Subcontractors Disclosure of Ownership.pdf **Description of Process:** Whenever a change occurs, Anthem notifies DHCFP of these changes.	☐ Met ☐ Partially Met ☒ Not Met ☐ NA
	Findings: The Delegate/Vendor Oversight & Management Program Description and policy did not include the requirement that the MCO must obtain approval from DHCFP prior to service start date and whenever there was a change in subcontractors. During the onsite review, Anthem provided the Delegate Terminations and De-delegations policy and procedure, which specified certain functions required the submission of the agreement to the State for approval prior to implementation. Although HSAG reviewers requested evidence to support that the delegated agreements were submitted to DHCFP for approval, Anthem did not provide documentation to support DHCFP reviewed and approved material subcontractors, or delegates, hired to perform requirements of the contract as indicated.		
	Recommendations: By the service start date and whenever a change occurs, Anthem must submit to DHCFP for review and approval the names of any material subcontractors hired to perform any of the requirements of the Contract and the names of their principals.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			