Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2019–2020 Compliance Review

for

Anthem Blue Cross and Blue Shield Healthcare Solutions

December 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

According to federal requirements located within Title 42 of the Code of Federal Regulations (CFR), 42 CFR §438.358, the state, an agent that is not a Medicaid managed care entity, or its external quality review organization (EQRO) must conduct a review to determine a managed care organization's (MCO's) compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. To comply with the federal requirements, the Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (the DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct compliance reviews of the MCOs managing the acute, primary, behavioral health, pharmacy, and other medical services for Nevada Medicaid and Nevada Check Up members. Nevada Check Up is the State's Child Health Insurance Program (CHIP) managed care program.

The purpose of the state fiscal year (SFY) 2019–2020 Compliance Review was to assess each MCO's compliance with the federal compliance review standards and the State contract requirements found in the DHCFP Contract 3260. The SFY 2019–2020 Compliance Review focused on the requirements for managed care operations. The review period was July 1, 2019 through December 31, 2019. This report details **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**)'s compliance review results as documented in the following compliance review tools:

- **Standards**: State and federal managed care requirements, which were categorized into four contract standards.
- **Corrective Action Plan (CAP) Review**: standards reviewed during the previous two years (SFY 2017–2018 and SFY 2018–2019) that received a score of *Partially Met* or *Not Met* and required the MCO to submit a CAP.

Anthem had an overall compliance score of 92 percent for all elements evaluated in the SFY 2019–2020 Compliance Review. Additionally, 12 out of 12 CAP elements were determined to be complete, indicating these prior deficiencies were remediated. Based on the findings of the review, **Anthem** demonstrated strong compliance with the federal and State requirements contained in its managed care contract.

2. Background

In July 2016, the State of Nevada, Purchasing Division, on behalf of the DHCFP, a Division of the State of Nevada, Department of Health and Human Services, solicited responses from qualified vendors to provide risk-based capitated MCO services designed in support of Title XIX (Medicaid) and Title XXI (CHIP—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

According to 42 CFR §438.358, which describes the activities related to EQRs, 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 Compliance Review Cycle for Anthem

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Provider Network Management			
I. Credentialing and Recredentialing	✓		
II. Availability and Accessibility of Services	✓		
III. Subcontracts and Delegation	✓		
IV. Provider Dispute and Complaint Resolution	✓		
V. Provider Information	✓		
Member Services and Experiences			
VI. Member Rights and Responsibilities		✓	
VII. Member Information		✓	
VIII. Continuity and Coordination of Care		✓	
IX. Grievances and Appeals		✓	
X. Coverage and Authorization of Services		✓	

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Managed Care Operations			
XI. Internal Quality Assurance Program			✓
XII. Cultural Competency Program			✓
XIII. Confidentiality			✓
XIV. Enrollment and Disenrollment			✓
XV. Program Integrity*			✓*

* Standard XV—Program Integrity was not reviewed by HSAG as the State conducted this review.

Purpose of the Review

The purpose of the SFY 2019–2020 Compliance Review was to determine **Anthem**'s compliance with federal and State Medicaid managed care standards related to managed care operations. The review period was July 1, 2019, through December 31, 2019. Additionally, the SFY 2019–2020 Compliance Review included a review of elements found to be deficient in years 1 and 2 of the compliance review cycle. The purpose of this review was to ensure that all action plans put in place to remediate the deficiencies were implemented, and that all elements within each of the standards reviewed during the three-year cycle are compliant.

3. Methodology

Compliance Review Process

The compliance standards were derived from the requirements as set forth in the *Department of Health and 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 of July 1, 2019, through December 31, 2019. HSAG followed the guidelines set forth in CMS' *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[3-1] to create the process, tools, and interview questions used for the SFY 2019–2020 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 the following activities as part of the compliance review:

Pre-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.
- Developing the managed care entity (MCE) questionnaire.
- Conducting a technical assistance session to assist the MCO in preparing for the compliance review.
- Scheduling the review.
- Developing the agenda for the review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a 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 virtual review.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2020.

Virtual review activities included:[3-2]

- An opening conference with introductions as well as a review of the agenda and logistics for HSAG's review activities.
- A review of the data systems that each MCO used in its operations, which includes, but is not limited to, 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 tool (compliance standards) shown in Appendix A, which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and actions required to bring each MCO's performance into compliance for those requirements that HSAG assessed as less than fully compliant. The results for the compliance standards are noted in Table 3-1 of this report.

Post review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created a CAP template, shown in Appendix C, which contains the findings and required actions 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 30 calendar days of receiving this report.**

Description of Data Obtained

To assess each MCO's 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:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers and subcontractors.
- 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, health management, and cultural competency.
- An MCE questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with each MCO's key staff members during the virtual review.

[3-2] Due to coronavirus disease 2019 (COVID-19), the on-site review was conducted virtually through a Webex session.

Compliance Standards Reviewed

Table 3-1 lists the standards reviewed to determine compliance with State and federal standards.

Table 3-1—Compliance Standards

Standard #	Standard Name	Number of Elements
XI	Internal Quality Assurance Program	21
XII	Cultural Competency Program	17
XIII	Confidentiality	11
XIV	Enrollment and Disenrollment	8
	Total Number of Elements	**57**

Data Aggregation and Analysis

Compliance 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 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (cited earlier in the report). 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 not 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 standard and an overall percentage-of-compliance score across the 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).

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 virtual review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCO's performance in complying with each standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- 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 members for their review and comment prior to issuing final reports.

Compliance Standards

From a review of documents, observations, and interviews with key health plan staff conducted during the virtual evaluation, the reviewers assigned **Anthem** a score for each element and an aggregate score for each standard. Table 4-1 presents **Anthem**'s scores for the compliance standards. Details regarding **Anthem**'s compliance with the four standards, including the score that **Anthem** received for each element within each standard, are found in Appendix A, SFY 2019–2020 Compliance Review Tool for **Anthem**.

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

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	Internal Quality Assurance Program	21	20	16	4	0	1	90%
XII	Cultural Competency Program	17	17	15	2	0	0	94%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	8	8	6	1	1	0	81%
Total Compliance Score		**57**	**56**	**48**	**7**	**1**	**1**	**92%**

***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.

The findings from the compliance review show how well an MCO has interpreted federal regulations and the managed care contract requirements and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. **Anthem** achieved full compliance in one of the four standards reviewed, demonstrating strengths and adherence to all requirements measured in the area of Confidentiality. The area with the greatest opportunity for improvement was related to Enrollment and Disenrollment, as this area received performance scores under 90 percent.

These findings suggest that **Anthem** developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrated compliance with the expectations of 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.

Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

CAP Review

Anthem was required to submit to the DHCFP a CAP for all elements scored *Partially Met* or *Not Met* in years 1 and 2 of the three-year compliance review cycle. To ensure the MCO had implemented plans of action to remediate the previously identified deficiencies, the DHCFP requested that HSAG conduct a follow-up review of the CAPs developed as a result of the deficiencies identified through the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

Table 4-2 presents **Anthem**'s scores for the CAP elements reviewed.

Table 4-2—Summary of Scores for the SFY 2017–2018 and SFY 2018–2019 CAP Reviews

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
I	Credentialing and Recredentialing	NA	NA	NA
II	Availability and Accessibility of Services	1	1	0
III	Subcontracts and Delegation	3	3	0
IV	Provider Dispute and Complaint Resolution	NA	NA	NA
V	Provider Information	NA	NA	NA
VI	Member Rights and Responsibilities	1	1	0
VII	Member Information	NA	NA	NA
VIII	Continuity and Coordination of Care	NA	NA	NA
IX	Grievances and Appeals	7	7	0
X	Coverage and Authorization of Services	NA	NA	NA
	Total	**12**	**12**	**0**

M=*Met* and ***NM***=*Not Met*

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

Total Number of Elements Scored: The number of elements that received a score of *M* or *NM* for each standard reviewed.

NA: The MCO did not have any deficiencies noted for this standard during the SFY 2017–2018 and SFY 2018–2019 reviews.

Of the 12 total elements reviewed, the MCO demonstrated compliance and received a score of *Met* for all elements. Details regarding **Anthem**'s compliance with the CAP review are found in Appendix B, 2020 Corrective Action Plan Compliance Review Tool.

5. Corrective Action Plan

Anthem is required to submit to the DHCFP a CAP for all elements scored *Partially Met* or *Not Met*. Appendix C contains the CAP template that HSAG prepared for **Anthem** to use in preparing its plans of action to remediate any deficiencies identified during the SFY 2019–2020 Compliance Review. The CAP template lists each element for which HSAG assigned a score of *Partially Met* or *Not Met*, as well as the associated findings and required actions documented to bring **Anthem** into full compliance with the deficient requirements. **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 30 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 plans of action/interventions that the MCO 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 MCO into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO 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 XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(a)(1) *DHCFP Contract Section 3.10.6, 3.10.6.1-2, 3.10.6.4, 3.10.6.5*	1. Written IQAP Description The MCO must establish and implement an ongoing comprehensive IQAP. *a) The MCO must have a written description of its IQAP.* *b) The written description must contain a detailed set of QA objectives, which are developed annually and include a timetable for implementation and accomplishment.* *c) The written description must provide for continuous performance of the activities, including tracking of issues over time.* *d) The written description must specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities must be clearly identified and qualified to develop the studies and analyze outcomes.*	**Documents Submitted:** 2019 QM Program Description 2019 QM Work Plan **Description of Process:** a. Please See attached 2019 QM Program Description b. QM Program Goals are listed on pages 5-6 and QM Program Objectives are listed on pages 7-8 of the attached 2019 QM Program Description. Timelines for QM activity completions are outlined throughout the attached 2019 QM Work Plan c. The QM Program incorporates continuous tracking and trending of quality indicators to ensure outcomes are measured and goals attained. Please see attached 2019 QM Program Description pages 7, 9, and 10. This language is also included in the Purpose and Scope section of the attached 2019 QM Work Plan, on page 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

[A-1] The Information Submitted as Evidence by the MCO column was completed by the MCO and has not been altered by HSAG except for minor formatting.

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		d. Our QM Work Plan outlines QM planned activities for the calendar year, responsible parties. Please see attached 2019 QM Work Plan for bookmarked and highlighted examples, labeled XI 1d – Example of Quality of Care analysis and Example of Quality of Care Study report. Clinical QM Leadership and the QM Committee structure also oversight study selection and ensure methodology is clearly defined, as part of the approval process.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.330(a)(1) *DHCFP Contract Section 3.10.6.3 (A-B)*	2. Scope *a) The scope of the IQAP must be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. Scope must also include availability, accessibility, coordination, and continuity of care.* *b) The IQAP methodology must provide for review of the entire range of care provided by the MCO, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** a. The QM Program Description outlines the scope of the IQAP and the critical elements of this requirement. Please see the attached 2019 QM Program Description that has bookmarks labeled XI 2a – Program Scope. b. The QM Program Description includes all member populations from birth through the advancing age populations. Numerous analyses and evaluations are	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.(the DHCFP expects that this review occurs no less than annually.)	conducted on the population serve to assess the effectiveness of clinical outcomes, member satisfaction and access, and to identify opportunities for improvement. Please see the attached 2019 QM Program Description with bookmarks labeled XI 2b. The attached 2019 QM Work Plan also has examples of activities conducted, no less than annually. See bookmark labeled XI 2b.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.330(b)(3) *DHCFP Contract Section 3.10.8.1 (D)*	3. Over- and Under-Utilization of Services The comprehensive IQAP must include mechanisms to asses both underutilization and overutilization of services, and to follow up appropriately. *a) If fraud and abuse is suspected, a referral must be made to the MCO's PIU and the DHCFP SUR Unit for appropriate action.*	**Documents Submitted:** 2019 UM Program Description **Description of Process:** Anthem is committed to ensuring access to health care and services for all participating members. Anthem facilitates delivery of appropriate care and monitors the impact of the UM program to detect and correct potential under-and over-utilization of services. Please see the attached 2019 UM Program Description with corresponding bookmarks labeled XI 3a.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Recommendations: The Provider Engagement presentation accompanied by the sample group scorecards was dated August 13, 2020, several months after the time period of review. HSAG strongly recommends that the MCO be mindful of, and adhere to, HSAG/DHCFP instruction pertaining to the time period for future compliance reviews as materials dated outside that period will not be accepted.		
	Required Actions: None.		
42 CFR §438.330(b)(4) *DHCFP Contract Section 3.10.8.3 (B)*	4. Special Health Care Needs The comprehensive IQAP must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *a) Multi-disciplinary teams are required, when appropriate, to analyze and address systems issues.*	**Documents Submitted:** 2019 UM Program Description PP Children with Special Health Care Needs - NV **Description of Process:** Utilization Management and Case Management activities are integrated into the QM Program and spelled out further in their own respective program description. Activities are reported to the MAC and QMC no less than annually. Please see attached 2019 UM Program Description for high-level overview of care coordination and corresponding bookmark labeled XI 4a – Special Health Care Needs. Please also reference the Children with Special Health Care Needs policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(b)(5)	5. Long-Term Services and Supports (LTSS) For MCOs providing LTSS: a) The IQAP must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the recipient's treatment/service plan. b) Participate in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on DHCFP for home and community-based waiver programs.	**Documents Submitted:** N/A **Description of Process:** N/A for Anthem Blue Cross and Blue Shield Healthcare Solutions Nevada	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: This element was informational only and, therefore, deemed *N/A* for this review. The MCO should be prepared to have this element scored during future compliance reviews. **Recommendations:** HSAG's understanding is that serious occurrences are reported via a DHCFP reporting form. HSAG requested an example of a reporting form; however, what was provided appeared to be an internal quality of care reporting form and not a DHCFP reporting form. HSAG recommends that the MCO collaborate with the DHCFP to clarify expectations and responsibilities regarding the serious occurrence reporting processes.		
	Required Actions: None.		
42 CFR §438.330(c)(2)(i-iii)	6. Performance Measurement The MCO must annually: a) Measure and report to DHCFP on its performance, using standard measures required by DHCFP.	**Documents Submitted:** 2019 QM Program Description 2018 QM Program Evaluation **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	b) Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP. c) Perform a combination of the above activities.	• a), b), c) For ease of referencing, please see the attached 2019 QM Program Description with corresponding book mark labeled XI 6 a, b, c – Performance Measurement and also the 2018 QM Program Evaluation, which as performance measurement and analysis throughout. QM Program activities are monitored continuously and a comprehensive evaluation is conducted no less than annually.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.8.1	7. Quality Indicators *Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area. The MCO is required to:* *a) Identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.* *b) Monitor and evaluate quality of care through studies which include, but are not limited to, the quality*	**Documents Submitted:** 2019 QM Program Description 2019 QM Work Plan **Description of Process:** a), b), c) Please see attached 2019 QM Program Description with corresponding bookmark labeled XI 7 a, b, c – Quality Indicators, 2 pages. In addition, please see the attached 2019 QM Work Plan which as indicators throughout. We called out two examples; HEDIS[A-2] Indicators and PIPs with	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

[A-2] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	indicators also specified by the CMS , with respect to the priority areas selected by DHCFP. c) *Ensure methods and frequency of data collection; ensure data accuracy; and ensure data is effective and sufficient to detect the need for program change.*	a bookmark labeled XI 7 a, b, c – Quality Indicator Examples (HEDIS and PIPs).	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** While many of the Internal Quality Assurance Program (IQAP) activities identified measurable performance goals, HSAG recommends that the MCO consider enhancing processes to set data-driven, objective, and measurable goals. The MCO should use the results of the previous year's activities to set measurable performance goals based on areas of low performance. Should goals be met year-over-year, the MCO should consider revising those goals.		
	Required Actions: None.		
42 CFR §438.330(d)(1), (2)(i-iv) *DHCFP Contract Section 3.10.7.6-7*	8. Performance Improvement Projects (PIPs) The comprehensive IQAP must include PIPs, including any PIPs that focus on clinical and non-clinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and recipient satisfaction and must include the following elements: a) Measurement of performance using objective quality indicators. b) Implementation of interventions to achieve improvement in the access to and quality of care. c) Evaluation of the effectiveness of the interventions based on the performance measures. d) Planning and initiation of activities for increasing or sustaining improvement.	**Documents Submitted:** 1. PP Study Selection, Design, Implementation and Evaluation QIPs; 2. State of Nevada Division of Health Care Financing and Policy 2018 – 2019 Performance Improvement Projects Report **Description of Process:** Anthem conducts health care quality performance improvement projects (PIPs) to assess and enhance processes, and thereby improve health outcomes, access to and quality of care. PIPs are designed, conducted, and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		reported using systematic and sound methodology to achieve real and verifiable improvements in care. PIPs target areas of clinical care and non-clinical services. Anthem relies on feedback from HSAG from prior years in order to refine PIPs. The topics selected for the projects reflect a significant portion of the enrollees (or a specified sub-portion of enrollees) and have a potentially significant impact on enrollee health, functional status, or satisfaction. The topics reflect high-volume or high-risk conditions of the population served. Each study has at least one study indicator (each indictor is objective, clearly defined, and based on current clinical knowledge or health services research), which is a quantitative or qualitative characteristic (variable) reflecting a discrete event (e.g., a child has/has not received an immunization in the last 12 months), or a status (e.g., an enrollee's blood pressure is/is not below a specified level) that is to be measured and used to track performance and improvement over time. Each indicator is capable of objectively measuring either enrollee outcomes such as	

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		health or functional status, enrollee satisfaction, or valid proxies of these outcomes. Anthem may use a representative sample to select members of the study population when applicable, as well as proper sample size and sampling techniques to provide valid and reliable information on the quality of care provided. The PIP specifies the true (or estimated) frequency of occurrence of the event, the statistical confidence interval to be used, and the acceptable margin of error when using sampling methods. PIPs are submitted to the quality committee(s) for feedback and discussion. Anthem conducts the following: 1. Collects valid (accurate) and reliable (repeatable or reproducible) data on study indicators. 2. Data collection plan with: • Clear identification of data to be collected • Identification of data sources and how and when the baseline and repeat indicator data will be collected • Specification of who will collect the	

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		data • Identification of instruments used to collect the data Anthem employs qualified and trained staff when manually collecting the data, prospectively specifying a data analysis plan that includes: I. Whether data are collected on entire population or a sample II. Whether measurements obtained from data collection activity were to be compared to results of previous or similar studies, multiple entities, etc. Anthem examines performance on selected clinical or non-clinical indicators according to the statistical analysis techniques defined in the data analysis plan and presents quantitative and qualitative study results and findings accurately, clearly and in an easily understandable manner, including: I. Initial and repeat measurements of identified indicators II. Statistical significance of differences between baseline and repeat measurements III. Factors that influence the comparability of	

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		initial and repeat measurements IV. Factors that may affect the validity of the findings V. An interpretation of the study results (e.g., hypothesis about causes of less-than-optimal performance and related data) VI. Comparison with benchmark data (e.g., National Medicaid data or industry standards) VII. Follow-up activities planned Anthem determines whether change represents "real" change or is an artifact of a short-term event unrelated to the intervention, or random chance by performing the following: I. Calculating the degree to which a change in performance is "statistically significant" and compares result with benchmark data II. Determining whether quantitative improvement in processes or outcomes of care according to predetermined project indicators III. Determining whether performance improvement has "face" validity (result of planned intervention or unrelated occurrence.) IV. Determining if there is statistical evidence that observed performance improvement is	

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		true improvement Anthem strives to demonstrate sustained improvement via repeated measurements over comparable time periods. Sustained improvement is demonstrated when two (2) consecutive re-measurements result in a statistically significant (or state approved calculation methodology) improvement. Anthem's PIPs aim to implement real, sustained and significant improvements in care and service by continuously measuring and thoroughly analyzing performance, and developing and implementing appropriate system-wide improvements. Improvement strategies are designed to change behavior at an institutional, practitioner or member level. The effectiveness of intervention activities is determined by measuring change in performance, according to predefined quality indicators. Interventions are undertaken based on the following criteria: I. Related to causes/barriers identified through data analysis and quality improvement processes.	

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		II. The interventions to improve quality indicators are system-wide, i.e., educational efforts, policy changes, allocation of additional resources, or other organizational initiatives to improve performance. III. If repeat measures indicate that quality improvement activities are not successful, i.e., did not achieve significant improvement, the problem-solving process begins again with data analysis to identify possible causes and to propose and implement solutions. IV. If quality improvement activities are successful, the new processes are standardized and monitored. Anthem retires PIPs upon notification by the EQRO and/or sate that a final study report has been validated and meets the PIP requirements.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.330(d)(3) *DHCFP Contract Section 3.10.7.5*	9. Implementation of PIPs The MCO is required to report the status and results of each project to DHCFP as requested, but not less than once per year.	**Documents Submitted:** 1. Follow Up after ER Discharge (FUM) RCI PIP (FUM.zip - Module submissions and validation feedback for each module);	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	a) The MCO is required to annually conduct and report on a minimum of two clinical PIPs and three non-clinical PIPs. *b) Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.*	2. Well-Child Visits for Children 3 to 6 Years of Age (W34) RCI PIP (W34.zip - Module submissions and validation feedback for each module) **Description of Process:** In accordance with RFP provisions, and HSAG requirements, Anthem produces PIP modules at the determined intervals. Anthem participates in monthly PIP Technical Assistance Meetings with HSAG, and submits each module for each PIP in accordance with the schedule outlined by HSAG.	
	Findings: While the MCO worked with HSAG to conduct and validate two State-required PIPs, MCO staff members were unable to confirm they had engaged in any other PIPs. After the virtual review, the MCO submitted an emergency (ED) department follow-up PIP report; however, it did not appear that the MCO's methodology for a PIP was followed and/or documented. **Recommendations:** HSAG strongly recommends that the MCO adhere to CMS EQR *Protocol 8. Implementation of Additional Performance Improvement Projects: An Optional EQR-Related Activity, October 2019* when conducting PIPs and ensure this is appropriately documented. All PIPs should be clearly identified and incorporated into the MCO's IQAP. Additionally, as the MCO is specifically required to conduct two clinical and three non-clinical PIPs annually, HSAG recommends that the MCO clearly identify in its IQAP the clinical and/or non-clinical focus of each PIP to ensure adherence to the requirements of this element.		
	Required Actions: The MCO must annually conduct and report on a minimum of two clinical PIPs and three non-clinical PIPs.		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(e)(2) *DHCFP Contract Section 3.10.8.7 (A-C)*	10. Program Evaluation The MCO must develop a process to evaluate the impact and effectiveness of its own IQAP. *a) The MCO must conduct regular and periodic examination of the scope and content of the IQAP to ensure that it covers all types of services in all settings.* *b) At the end of each calendar year, a written report on the IQAP must be prepared and submitted to DHCFP which addresses quality assurance studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the IQAP.* *c) The report should include evidence that quality assurance activities have contributed to significant improvements in the care delivered to members.*	**Documents Submitted:** 2019 QM Program Description 2018 QM Program Evaluation **Description of Process:** a), b), c) Please see attached 2019 QM Program Description with corresponding bookmark labeled XI 10 a, b, c – Program Evaluation, as well as the 2018 QM Program Evaluation with book marks corresponding to the letters/questions on the left.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.6.6 (A-B)	11. Provider Review *a) Review by physicians and other health professionals of the process followed in the provision of health services must be conducted.*	**Documents Submitted:** 2019 QM Program Description, Appendix B – Resources Dedicated to the Quality Management Program MAC Minutes August 20 2019	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	b) The MCO must provide feedback to health professionals and MCO staff regarding performance and patient health care outcomes.	**Description of Process:** a. Internal Medical Directors and Participating Practitioners participate in the review and approval of QM activities, studies, and the oversight of the QM Program. Please see the attached 2019 QM Program Description with corresponding bookmark for XI 11a – Provider Review & Other Health Professionals. In addition, see attached MAC Minutes August 20 2019 for examples of practitioner review, labeled XI 11a – Provider Review. b. Please see attached 2019 QM Program Description with corresponding bookmarks labeled XI 11b – Providing Feedback.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO enhance processes to share MCO performance (in addition to provider-specific data) with its provider network via newsletters, bulletins, websites, etc. The MCO should also clarify in its IQAP how it shares MCO performance with internal staff members.		
	Required Actions: None.		
DHCFP Contract Section 3.10.8.4, 3.10.8.5 (A-F)	12. Implementation of Corrective Actions *The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or*	**Documents Submitted:** 2019 QM Program Description **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	services that should have been furnished were not. These written corrective action procedures must include: *a) Specification of the types of problems requiring corrective action.* *b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems.* *c) Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff.* *d) The schedule and accountability for implementing corrective actions.* *e) The approach to modifying the corrective action if improvements do not occur.* *f) Procedures for terminating the affiliation with the physician, or other health professional or provider.*	a)-f), An evaluation of the QM Program is conducted on an annual basis. A critical part of this evaluation includes review and identification of quality initiatives that did not meet their goal, identification and analysis of issues or barriers to achieving goals, as well as recommended intervention or action to demonstrate improvement for the upcoming year. The evaluation and findings are presented to the MAC and QMC for leadership and provider input and recommendation. This also applies to Peer Review activities related to Credentialing/Recredentialing, as well as Delegation Oversight. Please see attached 2019 QM Program Description with corresponding bookmark labeled XI 12 a-f – Implementation of Corrective Actions with sub-bookmarks.	
	Findings: The Quality of Care—Core Procedure and Peer Review—NV policy included provisions as required by this element except for sub-element (e), which was not well defined. These policies lacked specificity related to the MCO's approach to: • Modify corrective actions if improvements do not occur. • Monitor and evaluate plans of action to assure required changes have been made. • Monitor changes in practice patterns. • Timely follow-up on identified issues to ensure actions for improvement have been effective. MCO staff members indicated that this monitoring would occur, on a case-by-case basis (for example, setting up a calendar to monitor progress); however, there is an area of opportunity for the MCO to clarify, in policy, expectations that specifically address the above provisions to ensure adherence to the contract requirements. **Recommendations:** HSAG recommends that the MCO consider a standardized format for documenting all activities conducted to monitor and evaluate the corrective action to assure required changes have been made; monitor changes in practice patterns; assure		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	timely follow-up on identified issues to ensure actions for improvement have been effective; and modify the corrective action if improvements do not occur.		
	Required Actions: The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include: • The approach to modifying the corrective action if improvements do not occur. The MCO must also: • Monitor and evaluate the plans of correction (POC) to ensure required changes have been made. • Monitor changes in practice patterns. • Assure timely follow-up on identified issues to ensure actions for improvement have been effective.		
42 CFR §438.330(b)(4) *42 CFR §438.330(d)* *DHCFP Contract Section 3.10.8.6*	13. Assessment of Effectiveness of Plans of Correction (POC) *a) As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made. In addition, changes in practice patterns must be monitored.* *b) The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** a), b) An evaluation of the QM Program is conducted on an annual basis. A critical part of this evaluation includes review and identification of quality initiatives that did not meet their goal, identification and analysis of issues or barriers to achieving goals, as well as recommended intervention or action to demonstrate improvement for the upcoming year. Please see the attached 2019 QM Program Description with corresponding bookmarks for XI 13 examples where actions are taken to improve care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Findings: HSAG has determined that the MCO has met the requirements for this element. However, opportunities for improvement were identified. As the MCO received a *Partially Met* score for these same opportunities for Element 12, the MCO received a *Met* score for this element. Refer to Element 12 for more details. **Recommendations:** HSAG recommends that the MCO consider a standardized format for documenting all activities conducted to monitor and evaluate the corrective action to assure required changes have been made; monitor changes in practice patterns; assure timely follow-up on identified issues to ensure actions for improvement have been effective; and modify the corrective action if improvements do not occur.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.1-4	14. Accountability to the Governing Body *The Governing Body of the MCO is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the MCO that is responsible for the MCO IQAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include:* *a) There is documentation that the Governing Body has approved the overall IQAP and the annual IQAP.* *b) The Governing Body has formally designated an entity or entities within the MCO to provide oversight of the IQAP and is accountable to the Governing Body, or has formally decided to provide such oversight as a committee of the whole.* *c) The Governing Body routinely receives written reports from the IQAP describing actions taken, progress in*	**Documents Submitted:** 2019 QM Program Description NV 2019-06-21 BOD Minutes QIC Minutes May 9 2019 QIC Minutes November 14 2019 **Description of Process:** a. Please see attached Board Minutes. b. The Health Plan Board of Directors (BOD) is responsible for organizational governance, in this capacity it is the governing body of the Quality Management Program. The Board designated the Medicaid Quality Improvement Committee (QIC) to oversee the Quality Program and activities. Please see attached 2019 QM Program Description with corresponding	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	meeting quality assurance objectives, and improvements made.	bookmark labeled XI 14b – Board of Directors. c. The Board routinely receives written reports from the IQAP description. The Board has designated the Medicaid QIC to oversee the Quality Program and activities. The QIC receives periodic updates regarding IQAP activities, actions taken, progress in meeting quality assurance objectives, and improvements made. Please see the attached minutes labeled "NV 2019-06-21 BOD Minutes", as well as the QIC minutes labeled "QIC Minutes May 9 2019" and "QIC Minutes November 14 2019" showing oversight of the Nevada QM Program.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. However, documentation did not support that the MCO provided regular written reports to the BOD outside of the annual IQAP review. MCO staff members explained that IQAP reporting occurs annually, while it used to occur quarterly. As the MCO received a *Partially Met* score for this same finding for Element 16, the MCO received a *Met* score for this element. Refer to Element 16 for more details. **Recommendations:** HSAG strongly recommends that the MCO include in its IQAP provisions and minimum reporting time frames for presenting to the BOD, routine written reports from the IQAP describing actions taken, progress in meeting quality assurance objectives, and improvements made. Discussion of these reports should be clearly documented in BOD meeting minutes.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.9.5 (A-D)	15. Annual IQAP Review *The Governing Body formally reviews on a periodic basis, but no less frequently than annually, a written report on the IQAP. This annual quality program evaluation report shall be submitted to the DHCFP in the second calendar quarter and at minimum must include:* *a) Studies undertaken.* *b) Results.* *c) Subsequent actions and aggregate data on utilization and quality of services rendered.* *d) An assessment of the IQAPs continuity, effectiveness and current acceptability.*	**Documents Submitted:** NV 2019-06-21 BOD Minutes **Description of Process:** The NV BOD formally reviews, at least annually, a written report on the IQAP. Please see attached NV BOD minutes labeled, "NV 2019-06-21 BOD Minutes".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.6	16. Program Modification *Upon receipt of regular written reports delineating actions taken and improvements made, the Governing Body must take action when appropriate, and direct that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.*	**Documents Submitted:** NV 2019-06-21 BOD Minutes **Description of Process:** The Nevada Board annually reviews and approves the written QM Program Description, QM Work Plan, and the QM Program Evaluation. In the last evaluation period, calendar year 2019, the Board approved the action plans developed for 2020 with no revisions or requests for modifications. Please	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		see attached NV BOD minutes labeled, "NV 2019-06-21 BOD Minutes".	
	Findings: Documentation did not support that the MCO provided regular written reports to the BOD outside of the annual IQAP review. MCO staff members explained that IQAP reporting occurs annually, while it used to occur quarterly.		
	Required Actions: The MCO must provide the BOD with regular written reports delineating actions taken and improvements made by the IQAP. The BOD must take action when appropriate, and direct that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO. This activity must be documented in the minutes of the meetings of the BOD in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.		
DHCFP Contract Section 3.10.10	17. Active QA Committee *The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the MCO. This committee or other structure must have:* *a) The structure/committee must meet on a regular basis with a specified frequency, no less than quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* *b) The role, structure and function of the structure/committee must be specified.* *c) There must be records documenting the structure and committee's activities, findings, recommendations and actions.* *d) IQAP subcommittees must be accountable to the Governing Body and must report to it (or its*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** a. The Quality Management Committee meets, at a minimum, four times per year. In calendar year 2019, the QMC met this requirement and met six times. Additional Ad hoc meetings we also held during 2019. Please see the attached 2019 QM Program Description with corresponding bookmark labeled, "XI 17s – Quality Committee Structure". b. Please see the attached 2019 QM Program Description with bookmark labeled, "XI 17b – Purpose and Responsibilities".	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	designee) on a scheduled basis on activities, findings, recommendations and actions. *e) There must be active participation in the IQAP committee from MCO providers, who are representative of the composition of the MCO's providers.*	c. Meeting activity is recorded in minutes. Please see the attached 2019 QM Program Description with corresponding bookmark labeled, "XI 17c – Committee Minutes". d. QM Sub-Committees are accountable for reporting to the QMC. Please see attached 2019 QM Program Description for an example of a sub-committee and its reporting structure/accountability. Bookmark labeled, "XI 17d – QM Sub-Committee Example". e. There is active participation by health plan Medical and Behavioral Health Medical Directors, as well as practitioners from the community. Please see attached 2019 QM Program Description with corresponding book marks, XI 17e – MCO Provider Participation" and "Participating Practitioners".	
	Findings: The MCO demonstrated limited participation of network providers in the IQAP (and IQAP committee) outside of the Medical Advisory Committee (MAC). While the MAC reports to the Quality Management Committee (QMC), no QMC meeting minutes were provided to confirm adequate reporting and communication between the MAC and QMC. Additionally, while MCO staff members explained they also solicited input from the provider network through the Joint Consumer and Provider Advisory Committee, which reported to the QMC, the non-MCO attendees only included three members and zero providers. Additionally, while HSAG received Quality Improvement Committee (QIC) meeting minutes, which was described as a corporate or regional		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	committee, HSAG would have expected the MCO to have an active IQAP committee at the local level overseeing its IQAP for the Nevada Medicaid program. HSAG requested examples of QMC meeting minutes; however, none were received.		
	Required Actions: The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the MCO. This committee or other structure must: • Meet regularly with a specified frequency, no less than quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions. • Have a specified role, structure, and function. • Maintain records documenting the structure and committee's activities, findings, recommendations, and actions. • Have IQAP subcommittees that are accountable to the Governing Body and report to it (or its designee) on a scheduled basis on activities, findings, recommendations, and actions. • Ensure the MCO providers actively participate in the IQAP committee as representatives of the composition of the MCO's providers.		
DHCFP Contract Section 3.10.11	18. IQAP Supervision *There must be a designated senior executive who is responsible for IQAP implementation. The MCO's Medical Director has involvement in quality assurance activities.*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** The Chief Executive Officer (CEO) is the senior executive responsible for the QM Program. The MCO Medical Director provides the overall direction and support to the QM Program and is responsible for oversight of clinical quality improvement operations. Please see attached 2019 QM Program Description with corresponding bookmarks labeled, "XI 18 – Designated Senior Executive" and sub-bookmark "Medical Director".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.12	19. Adequate Resources *The IQAP must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** Please see attached 2019 QM Program Description with corresponding bookmark labeled, "19 – Adequate Resources, 5 pages".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.13	20. Provider Participation in IQAP *a) Participating physicians and other providers must be kept informed about the written IQAP through provider newsletters and updates to the provider manual.* *b) The MCO must include in its provider contracts and employment agreements, for physician and non-physician providers, a requirement securing cooperation with the IQAP.* *c) Contracts must specify that hospitals and other vendors will allow the MCO access to the medical records of its members.*	**Documents Submitted:** NV Provider Manual Effective 5-2019 To Present PCP Contract Example Executed 080819_Redacted **Description of Process:** a. Participating physicians and other providers are kept informed about the QM Program through the Provider Manual. Please see attached NV Provider manual Effective 5-2019 To Present, with corresponding bookmark labeled, "XI 20a – Quality Management Program, 10 pages". We also make information about our QM Program available on the Provider Website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		https://mediproviders.anthem.com/nv/pages/quality-management.aspx b. All practitioner contract have language about cooperating with the QM Program. Please see attached PDF titled PCP Contract Example Executed 080819 Redacted, with corresponding bookmark labeled, "XI 20b – Participation with Quality". c. All practitioner/hospital contract have a provision requiring access to medical records. Please see attached example PDF. The language in this PDF is identical in all contract types and is titled PCP Contract Example Executed 080819 Redacted, with corresponding bookmark labeled, "XI 20c – Access to Medical Records".	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the MCO did not specifically inform providers of the written IQAP via a provider newsletter, it did communicate general information pertaining to the written IQAP via the provider manual and its website. The MCO should also communicate a reminder to providers on the written IQAP on an ongoing basis. This information should include IQAP updates and performance.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.22.1	21. Coordination of QA Activities with Other Management Activity *The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported within the MCO's organization and through the established QA channels.* *a) Quality assurance information is used in credentialing, recredentialing, and/or annual performance evaluations.* *b) Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of recipient grievances and appeals.* *c) There is a linkage between quality assurance and the other management functions of the MCO such as:* *i. Network changes.* *ii. Benefits redesign.* *iii. Medical management systems (e.g., pre-certification).* *iv. Practice feedback to practitioners.* *v. Patient education.* *vi. Recipient services.*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** a. Quality information is used in the credentialing and recredentialing process. Please see attached 2019 QM Program Description with corresponding bookmark labeled, "XI 21a – Quality Information – Credentialing/Recredentialing, 2 pages". b. Throughout the QM Program Description are sections illustrating how the QM Program is integrated into health plan operations and includes UM, Risk management, monitoring of member grievances and appeals, and much more. A summary of these activities can also be located in the QM Program Objectives. Please see the attached 2019 QM Program Description with corresponding bookmark labeled, "XI 21b – Quality Coordination, 2 pages". c. There is a variety of analyses and reports brought to the MAC and QMC each year, representing numerous member and provider topics. These	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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		reports and analysis drive change by identifying barriers and opportunities for improvement. Please see attached 2019 QM Work Plan for examples activities conducted throughout the year. See bookmark labeled, "XI 21c – Examples of Planned Activities, 8 pages".	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the MCO demonstrated that quality assurance information was used in credentialing as required by this element, the MCO should be prepared to demonstrate a review of data from grievances and appeals; results of quality reviews; utilization management; and member satisfaction surveys during future reviews of recredentialing files, as required under Contract 3.10.15.6(C).		
	Required Actions: None.		

Results for Standard XI: Internal Quality Assurance Program						
Total Elements	Met	= 16	X	1.00	=	16.00
	Partially Met	= 4	X	.50	=	2.00
	Not Met	= 0	X	.00	=	.00
	Not Applicable	= 1	X	.00	=	.00
	Total Applicable	= 20	**Total Rate**		=	18.00
Total Rate ÷ Total Applicable			**= Total Score**			**90%**

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(1)	1. The Cultural Competency Plan (CCP) *The CCP must be updated annually and submitted to DHCFP in the second quarter of each calendar year.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description 2019 Anthem Nevada Trilogy (CCP) submission **Description of Process:** Anthem creates/updates our CLAS and Health Disparities Program Description no less than annually and submits to DHCFP in the second quarter each year. Please see attached PDF document titled 2019 CLAS and Health Disparities Program Description.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (A)(1)	2. Contents of the CCP *The CCP must describe how care and services are delivered in a culturally competent manner.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** Throughout the 2019 CLAS and Health Disparities Program Description it discusses how care and services are delivered in a culturally competent manner. Please see examples excerpts bookmarked, XII 2 – Health Services Delivery In Cultural Competent Manner and sub-bookmarks. More examples can be found throughout.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The 2019 Culturally and Linguistically Appropriate Services (CLAS) and Health Disparities Program Description included descriptions on how care and treatment were provided in a culturally competent manner. Strategies to		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	support culturally competent service delivery such as hiring practices to support diversity, an annual assessment of member demographics, staff and provider training programs, interpreter services, and translation of member materials were also included in the CCP. The MCO should consider implementing additional strategies to enhance the delivery of culturally competent services and include them in the CCP. Such strategies could include coordination with traditional healers and community health workers, the incorporation of culture-specific attitudes and values into health promotion tools, inclusion of family and community members in healthcare decision making, and seeking to expand the provider network to include clinics in geographic areas that are easily accessible for certain populations.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (A)(2)	3. Staff Involved in the CCP *The MCO CCP must identify a staff person, title or position responsible for the CCP. If there is a change in the staff member responsible for the CCP, the MCO notifies the DHCFP.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** The Chief Executive Officer (CEO) oversee the CLAS and Health Disparities Program through review of an annual Program Description, Work Plan, and Annual Evaluation. Various corporate and health plan committees are responsible for implementation, monitoring, and assessment of the Program. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmark labeled, "XII 3 – Staff Person Responsible For CCP".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(3)	4. Staff Recruitment and Retention *The CCP must contain a description of staff recruitment and retention. The MCO must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the MCO's members. Cultural competence is part of job descriptions.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** Anthem recruits and employs qualified leadership, management, and staff to administer and support Plan services and programs. Bilingual associates are recruited to reflect the demographics of membership in specific job positions. Anthem is committed to attracting, retaining, developing, and advancing a world class workforce representative of the views, perspectives, experiences, and health care needs of a diverse population of consumers. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmarks labeled, "XII 4 – Staff Recruitment and Retention".	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The job description example (Community Relations Representative 1) listed as a qualification that a bilingual English/Spanish speaking individual was strongly preferred. The job description included a statement at end that identified the MCO as a 2018 DiversityInc Magazine Top 50 Company for Diversity. No other reference to cultural competence was noted in the job description.		
	Required Actions: The MCO must ensure that cultural competence is part of its job descriptions.		
DHCFP Contract Section 3.4.2.15 (B)(1)	5. Training Program *The training program:* *a) Consists of the methods the MCO uses to ensure that staff at all levels and across all disciplines receive ongoing education and training in*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** a), b), c) Training is an important part of our Cultural Competency initiative, tied to the Anthem Consumer Promise. The training course Becoming	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	culturally and linguistically appropriate service delivery to members of all cultures; *b) Is regularly assessed to determine the training needs of the staff, and the MCO updates the training programs; and* *c) Is customized based on the nature of the contracts the MCO has with providers and/or members.*	Culturally Competent is required for all new associates. All associates complete a cultural competency training course annually, and we offer a different training module for Physical Health Case Managers, Behavioral Health Case Managers, and Outreach Staff. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmarks labeled, "XII 5 – Training Programs, 2 pages".	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (B)(2)	6. Education Program *The education program:* *a) Consists of methods the MCO uses for providers and other subcontractors with direct member contact;* *b) Is designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** a), b) Cultural competency within the provider network and subcontractors is fostered through training and provision of resource materials and tools. Training is designed to make providers, office staff, and subcontractors aware of the importance of providing services in a culturally competent manner. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmarks labeled, "XII 6 & 7 Education Program and Training Providers and Subcontractors".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (B)(2)	7. Training Providers and Subcontractors *The MCO must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description. **Description of Process:** Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmark labeled, "XII 6 & 7 Education Program and Training Providers and Subcontractors".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	8. Culturally Competent Services and Translation/Interpretation Services *The MCO describes the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the MCO's members.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** Annual and ongoing assessments are conducted on our population to evaluate the cultural diversity of our membership. Please see the attached 2019 CLAS and Health Disparities Program Description and corresponding bookmark labeled, "XII 8 – CLAS Evaluation" and sub-bookmark "Member Demographic Assessment".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (C)(1)	9. Regular Assessment of Needs *A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the MCO's membership.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description. **Description of Process:** Annual and ongoing assessments are conducted on our population to evaluate the cultural diversity of our membership. Please see the attached 2019 CLAS and Health Disparities Program Description and corresponding bookmark labeled, "XII – CLAS Evaluation" and sub-bookmark "Member Demographic Assessment".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	10. Evaluating the Network *Culturally competent care requires that the MCO regularly evaluate its network, outreach services, and other programs to improve accessibility and quality of care for its membership. It also must describe the provision and coordination needed for linguistic and disability-related services.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description 2018 CLAS and Health Disparities Program Evaluation **Description of Process:** As part of the ongoing and annual assessment we evaluate our network and evaluate our outreach services and other programs to improve accessibility and quality of care for our membership. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmark labeled, "XII 10 – Evaluating the Network". For internal staff, this is addressed in the hiring and retaining sections of the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		CLAS Program and we have also included those bookmarks here as well. In addition, please see the attached 2018 CLAS and Health Disparities Program Evaluation for examples of evaluations conducted.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.10(d)(5)(i) *DHCFP Contract Section 3.4.2.15 (C)(2)*	11. Translation Services *The MCO must make members aware that translation services are available and will be provided by someone who is proficient and skilled in translation language(s). The availability and accessibility of translation services is not predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for translation purposes, but members must not be encouraged to substitute a friend or relative for translation services.* *(Note: Verification of 15 languages as required by Section 1557 of ACA)*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description Member Handbook (effective 8-2019 to present) **Description of Process:** In support to effective communication with health plan associates and providers, oral interpreter services are available at no cost to members 24 hours a day, 7 days a week. Interpretation services include sign language interpreter support. Members are informed of available translation services in the Member Handbook and member newsletter. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmark labeled, "XII 11 – Translation Services" and Member Handbook with bookmark labeled, "XII 11 – Language Assistance".	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.10(h)(1)(vii)	12. Providers' Cultural and Linguistic Capabilities *The MCO must make members aware of the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.*	**Documents Submitted:** Member Handbook (effective 8-2019 to present) Provider Director Screenshot – Languages Example.pdf **Description of Process:** The attached Member Handbook instructs members to visit the Member Website to access or download a provider directory. Please see attached Member Handbook (effective 8-2019 to present) with corresponding bookmark labeled, "XII 12 – Provider Directory" and PDF titled Provider Directory Screenshot – Languages Example.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Handbook directed members to the MCO's Member Website to access the provider directory in both English and Spanish. The English online provider directory identified what languages are spoken at the provider's office as well as whether the provider had received cultural competency training. While the Spanish online provider directory identified what languages were spoken in provider offices, it did not identify if the provider had received cultural competency training as required by federal rule.		
	Required Actions: The MCO's Spanish online provider directory must identify if providers have received cultural competency training as required by federal rule.		
DHCFP Contract Section 3.4.2.15 (C)(3)	13. Quality Review of Translated Material *The MCO must demonstrate that it uses a quality review mechanism to ensure that translated materials convey intended meaning in a culturally appropriate manner.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description PP Culturally and Linguistically Appropriate Services PP Member Materials Appropriateness **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Anthem translates written information materials into non-English languages at no cost to the member. Documents that are translated internally are required to go through the Anthem Collateral Material Approval Process, which ensures accuracy of materials being translated. Translation vendors meet quality standards established by contractual agreement and regulatory agencies. Contracts contain quality assurance requirements that must be adhered to. Translation vendors are required to submit an affidavit of accuracy and attest to meeting established quality standards for written material translation. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmarks labeled, "XII 13 - Translation Services".	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438/10(d)(1-2) *DHCFP Contract Section 3.4.2.15 (C)(3)(a)*	14. Ten Percent Threshold for Providing Written Translation *All materials shall be translated when the MCO is aware that a language is spoken by 3,000 or 10 percent (whichever is less) of the MCO's members who also have Limited English proficiency (LEP) in that language.*	Documents Submitted: 2019 CLAS and Health Disparities Program Description PP Member Materials Appropriateness Description of Process: At least every three years, the language profile of membership is assessed. The Anthem Enterprise Data Warehouse is used to collect language profile data. In addition to the Enterprise Data, a threshold language assessment is conducted with American Community Survey (ACS) data, which reports	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		languages spoken by 5 percent or 1,000 eligible individuals, as outlined in the NCQA population language profile standard. Vital documents are documents or portions of documents that, without written translation, would lack meaningful access to Health Plan products and services for individuals with Limited English Proficiency (LEP). Documents not initially translated contain a Language Assistance Program (LAP) notice.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438/10(d)(1-3) *DHCFP Contract Section 3.4.2.15 (C)(3)(b)*	15. Five Percent Threshold for Providing Written Translation *All vital materials shall be translated when the MCO is aware that a language is spoken by 1,000 or 5% (whichever is less) of the MCO's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, appeal and grievance notices, provider directories, and vital information from the member handbook.*	**Documents Submitted:** PP Member Materials Appropriateness 2019 CLAS and Health Disparities Program Description **Description of Process:** Anthem will follow the guidance of our state partner to identify the prevalent non-English language in the Nevada market. Please find language in our Member Materials Appropriateness policy, page 12 and CLAS and Health Disparities Program Description.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (C)(3)(c)	16. Written Notices Informing Members of Interpretation and Translation Services *All written notices informing members of their right to interpretation and translation services shall be translated into the appropriate language when the MCO's caseload consists of 1,000 members that speak that language and have LEP.*	**Documents Submitted:** PP Member Materials Appropriateness PP Distribution of Materials - Producing Medicaid Marketing Materials **Description of Process:** Anthem will follow the guidance of our state partner to identify the prevalent non-English language in the Nevada market.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (D)(1)	17. Evaluation and Assessment of CCP *a) The MCO must evaluate the CCP to determine its effectiveness and identify opportunities for improvement.* *b) A summary report of the evaluation must be sent to DHCFP.* *c) The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or MCO employee surveys. If issues are identified, they must be tracked and trended, and actions must be taken to resolve the issue(s).*	**Documents Submitted:** 2018 CLAS and Health Disparities Program Evaluation **Description of Process:** a), b), c) At least annually, the health plan conducts a comprehensive evaluation of the CCP. Please see the attached 2018 CLAS and Health Disparities Program Evaluation with helpful bookmarks illustrating the different metrics and data points evaluated, including the overall effectiveness.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Results for Standard XII: Cultural Competency Program							
Total Elements	Met	=	15	X	1.00	=	15.00
	Partially Met	=	2	X	.50	=	1.00
	Not Met	=	0	X	.00	=	.00
	Not Applicable	=	0	X	.00	=	.00
	Total Applicable	=	17	**Total Rate**		=	16.00
Total Rate ÷ Total Applicable				**= Total Score**			**94%**

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.224 *45 CFR parts 160 and subparts A and E of 164* *DHCFP Contract Section 3.10.16.9*	1. Confidentiality of Member Information The MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and subparts A and E of 164, to the extent that these requirements are applicable. *a) The MCO acts to ensure that the confidentiality of specified member information and records is protected.* *b) The MCO must establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records.*	**Documents Submitted:** PP Purpose and General Rules of the Privacy Policies PP Safeguards PP Disclosure with Authorization PP Verification and Authentication Verification & Disclosure Guide Medicaid Screen Shots **Description of Process:** The MCO has Policies and Procedures in place to ensure the confidentiality of member information. Reasonable administrative, technical and physical safeguards have been implemented to protect confidential information from unauthorized use and disclosure.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (B)*	2. Office Sites Maintaining Confidentiality of Member Information *The MCO must ensure that member care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.*	**Documents Submitted:** PP Safeguards policy PP Disclosure of PHI Outside of Anthem PP Clean Desk Anthem Privacy Audit_ Maryland Pkwy Walkthrough 0819	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process: The MCO has safeguards in place to ensure the protection and confidentiality of member information and ensures that the appropriate Verification and Authentication process is completed prior to disclosing information.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (C)(1-3)*	3. Releasing Confidentiality of Member Information *The MCO holds confidential all information obtained by its personnel about members related to their examination, care and treatment, and does not divulge it without the member's authorization, unless:* *a) It is required by law, or pursuant to a hearing request on the member's behalf;* *b) It is necessary to coordinate the member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or* *c) It is necessary in compelling circumstances to protect the health or safety or an individual.*	**Documents Submitted:** PP Specialized Non-Routine Disclosures (No Authorization Required) PP Treatment Payment and Health Care Operations Disclosures PP Disclosure of PHI Outside of Anthem PP Disclosure with Authorization PP Required By Law Disclosure Procedure PP Averting Serious Threat to Safety Disclosure Procedure MF-ANV-0011-17 NV PRV HIPAA Auth Form Anthem Code of Conduct **Description of Process:** The MCO has necessary processes and procedures in place to ensure disclosure	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		outside the company is in compliance with privacy regulation/HIPAA.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *45 CFR §164.410*	4. Reporting Inappropriate Use and Disclosure of Protected Health Information (PHI) to DHCFP The MCO promptly reports to DHCFP any inappropriate use or disclosure of PHI, including a breach of unsecured PHI as required by 45 CFR §164.410 and any security incident the MCO has knowledge of or reasonably should have knowledge of under the circumstances.	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting; PP Disclosures to State Medicaid Agencies **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** Although the MCO had a policy to support its obligation to notify regulators of any confirmed incident, including breaches, the MCO received a communication from the DHCFP Privacy Officer in 2014 indicating the MCO was required only to report breaches to the U.S. Department of Health and Human Services (HHS), Office of Civil Rights (OCR) and that it did not have an obligation to report incidents directly to the DHCFP since the contract did not require a business associate agreement. HSAG recommends that the MCO work with the DHCFP to determine the expectations for reporting privacy and security incidents to the DHCFP, even if those reports are for awareness only. The MCO still has obligations to report breaches directly to HHS OCR as required by federal rule.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (E)*	5. Requirements for Confidentiality of Patient Information *The MCO may disclose member records whether or not authorized by the member, to qualified personnel,*	**Documents Submitted:** PP Treatment Payment and Health Care Operations Disclosures PP Disclosures to State Medicaid Agencies	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	defined as persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State agency.	**Description of Process:** The MCO has policies and procedures in place for permitted disclosures of member information to qualified personnel/agency representatives that are subject to comparable standards of confidentiality.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(a)	6. Discovery of a Breach The MCO, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCO to have been accessed, acquired, used, or disclosed as a result of such breach.	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(b)	7. Timeliness of Notification Except as provided in §164.412 (law enforcement delay), the MCO provides notification to the individuals affected by a breach without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach.	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
45 CFR §164.404(c)(1-2)	8. Content of Notification The notification required by paragraph (a) of this section shall include, to the extent possible: a) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b) A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c) Any steps individuals should take to protect themselves from potential harm resulting from the breach; d) A brief description of what the covered entity involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address. f) Shall be written in plain language.	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
45 CFR §164.404(d)(1)(i-ii)	9. Method of Notification The notification shall be provided in the following form: a) Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available. b) If the MCO knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of subpart E), written notification by first-class mail to either the next of kin or personal representative of the individual. The notification may be provided in one or more mailings as information is available.	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(d)(2)	10. Substitute Notice In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual shall be provided. a) Substitute notice need not be provided in the case in which there is insufficient or out-of-date	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	contact information that precludes written notification to the next of kin or personal representative of the individual under paragraph (d)(1)(ii). b) In the case in which there is insufficient or out-of-date contact information for fewer than 10 individuals, then such substitute notice may be provided by an alternative form of written notice, telephone, or other means. c) In the case in which there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice shall: i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the Web site of the covered entity involved, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside; and ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured protected health information may be included in the breach.		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
45 CFR §164.404(d)(3)	11. Additional Notice in Urgent Situations In any case deemed by the covered entity to require urgency because of possible imminent misuse of unsecured protected health information, the MCO may provide information to individuals by telephone or other means, as appropriate.	**Documents Submitted:** PP Privacy and Security Incident Response and Reporting **Description of Process:** Please see attached documentation for full description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Results for Standard XIII: Confidentiality						
Total Elements	Met	= 11	X	1.00	=	11.00
	Partially Met	= 0	X	.50	=	.00
	Not Met	= 0	X	.00	=	.00
	Not Applicable	= 0	X	.00	=	.00
	Total Applicable	= 11	**Total Rate**		=	11.00
Total Rate ÷ Total Applicable			**= Total Score**			**100%**

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.5.1	1. Eligibility and Enrollment Functions *The MCO shall establish and implement enrollment procedures and maintain applicable enrolled member data.*	**Documents Submitted:** See Attachments • PP Membership Load - Facets • E and B Medicaid Quarterly Scorecards Q3 & Q4 2019 (see Quality Audit tab – West Region) **Description of Process:** Enrollment receives information regarding member activity via written communication and State Medicaid enrollment files. Written communications are routed to the Enrollment Department and the requested enrollment transaction is verified by the Enrollment Analyst and then posted to Facets via real time processing screens. State Medicaid enrollment files are processed through batch jobs. Enrollment receives transactions based on full monthly roster files and daily changes files. Enrollment data is supplied electronically over a secure website. The enrollment process begins with the receipt of the State Medicaid Enrollment file. The processing of the State eligibility/enrollment files is divided into several phases. A. State eligibility/enrollment files are compliance checked.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		B. The enrollment load process will perform load edits and generate a Membership Management System (MMS) Keyword file. C. The MMS Batch Load will perform additional edits and verifications and loads the data into the Facets Enrollment Subsystem. D. Load errors are processed via the FET (Facets Editing Tool) error recycling phase. Throughout the various phases of the process, reports are generated for validation and edit purposes. Load reports are generated providing an audit trail of the data that is received on the State Medicaid files and is subsequently loaded into Facets	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.5.5, 3.5.7.8	2. Change in Status *The MCO must notify a member that any change in status, including family size and residence, must be immediately reported by the member to their DWSS eligibility worker.* *a) Within seven (7) calendar days of becoming aware of any changes in a member's status, including changes in family size and*	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 65) NV_DEMOG_110119 NV SOBRA File 201910100916_RECIPD10 Anthem Expired Member Notification 1119 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	residence, the MCO must electronically report the change(s) to the DHCFP via the provider supplied data file. *b) The MCO must provide DHCFP with notification of all births and deaths and demographic changes.*	a) Members are notified via the member handbook that any change in status must be reported to their caseworker. Anthem submits demographic change files electronically to DHCFP on a daily basis or as changes are received (see NV_DEMOG_110119). b) Anthem submits SOBRA birth/delivery files to DHCFP electronically on a weekly basis (see NV SOBRA File 201910100916_RECIPD10). Notification of expired members are submitted to DHCFP's managedcaresupport@dhcfp.nv.gov mailbox.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. Additionally, sub-elements (a) and (b) were determined to be not applicable.		
	Required Actions: None.		
42 CFR §438.56(d)(1)(ii) *DHCFP Contract Section 3.5.7.3 (F)(1)(a-d)*	3. Member Request for Disenrollment The member must submit an oral or written request to the MCO to process disenrollment requests. *a) Any member may request to switch MCO's for good cause (as defined in 42 CFR 438.56(d)(2)) at any time.*	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67, 68) PP Member Request for Disenrollment-NV Member Disenrollment Form Disenrollment Denial Letter Disenrollment Acknowledgement Letter.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) These members must contact their current MCO orally or in writing for permission to disenroll.	**Description of Process:** See documents, the member handbook outlines the recipients rights of enrollment in the Medicaid program and the requirement for enrollment in an MCO. Recipients may request disenrollment from the MCO to another MCO during open enrollment and for good cause reasons, defined by DHCFP, outside of open enrollment.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(e)(1-2) *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (G)*	4. Sufficient Cause to Disenroll *If the MCO determines that there is sufficient cause to disenroll, they will notify the DHCFP by using the form supplied.* *a) The MCO must make a determination as expeditiously as the member's health requires and within a timeline that may not exceed fourteen (14) calendar days following receipt of the request for disenrollment.*	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67, 68) PP Member Request for Disenrollment-NV Anthem Member Disenrollment Form Disenrollment Denial Letter Disenrollment Acknowledgement Letter. **Description of Process:** 1. The QM Director must review the disenrollment request and make an approval or denial determination within 14 calendar days of receipt of the disenrollment request or as expeditiously as the member's health requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		2. A written notice of determination must be mailed to the member or the member's representative within 10 calendar days of the decision. The notice of decision includes the decision (approved or denied), the reason for the decision and how the member can appeal an adverse decision. (see below) 3. If the disenrollment request was approved, the Quality Management department faxes the approval (the Disenrollment Form) to the DHCFP Business Lines Unit (BLU). Denial decisions do not need to be faxed to DHCFP BLU.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** During the review, MCO staff members indicated disenrollment decisions are made within 14 days of the request for disenrollment. The Member Handbook and Member Request for Disenrollment policy indicated that disenrollment requests are reviewed within 14 days; however, these documents also inaccurately stated that the member would receive a letter within 10 days after the decision was made. After the review, the MCO sent updated documents to support that updates had been made to the policy and Member Handbook. HSAG recommends that the MCO review all documents to ensure that all materials indicate that the decision and notice will be sent to the member within 14 days.		
	Required Actions: None.		
42 CFR §438.56(c)(1) *42 CFR §438.56(d)(2)(i-v)* *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)*	5. MCO Denies Request to Disenroll *If the MCO denies the request for disenrollment for lack of good cause the MCO must send a Notice of*	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67, 68) PP Member Request for Disenrollment-NV	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.5.7.3 (H)	*Decision in writing to the member upon the date of the decision.* *a) Appeal rights must be included with the Notice of Decision.* *b) The MCO is required to inform the member of their right to first appeal through the MCO and if the appeal is denied to request a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1).*	Member Disenrollment Form Disenrollment Denial Letter Disenrollment Acknowledgement Letter. **Description of Process:** Member requests for appeal of disenrollment denials must be received at the Health Plan within 30 days of the date of the disenrollment denial notice of action. 1. When a written appeal request is received at the health plan, an acknowledgement letter sent to member within 5 days. 2. Investigation of appeal is conducted through the appeal process. 3. A senior administrator who was not involved in the initial denial will review the case to determine if "good cause" guidelines are met. 4. The appeal decision is completed and Notice of Decision letter is sent to member within 30 days of receipt of appeal request. o The notification of denial of appeal request includes information on member rights	

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		to a State Fair Hearing, how to obtain hearing and representation rules.	
	Findings: The MCO's Member Handbook and Member Request for Disenrollment policy indicated that disenrollment requests are reviewed within 14 days; however, these documents inaccurately stated that the member would receive a letter within 10 days after the decision was made instead of upon the date of decision, as required. A redacted disenrollment decision letter showed the letter was drafted on September 27 for a disenrollment request received on September 24. The letter did not include a date of decision; so, the time between the decision and the mailing of the letter could not be confirmed. Additionally, although the Notice of Decision template letter and redacted letter included appeal and State fair hearing rights, the letters included inaccurate appeal and State fair hearing time frames. After the virtual review, the MCO updated the appeal and State fair hearing time frames within its Notice of Decision letter and policy to 60 and 120 days, respectively.		
	Required Actions: If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a Notice of Decision in writing to the member upon the date of the decision. The MCO must also ensure that the member receives appeal and State fair hearing rights with accurate time frames.		
42 CFR §438.56(d)(5)(i-ii) *42 CFR §438.56(e)(1)* *DHCFP Contract Section 3.5.7.3 (I)*	6. Use of the MCO's Grievance System *DHCFP requires that the member seek redress through the MCO's grievance system before making a determination on the member's request.* a) The grievance process must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the member files the request.	**Documents Submitted:** NVNV_caid_MemberHandbook_eng.pdf (Pages 64-65) PP Member Request for Disenrollment-NV Disenrollment Denial Letter Disenrollment Acknowledge Letter NV Disenrollment Withdrawal Letter **Description of Process:** Members have the right to request disenrollment from the MCO to another MCO	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		during open enrollment or for good cause reasons as defined by The Division of Health Care Financing and Policy (DHCFP), outside of open enrollment. If the member is within the first 90 days of enrollment in the MCO, the member can submit the request directly to HPES, the Medicaid Vendor. After 90 days, members or their representatives must either complete the state approved Disenrollment Form or send a letter to the MCO asking to disenroll. Requests submitted after 90 days after enrolling with the MCO must be for a good cause reasons as defined by DHCFP. The MCO will make a determination within 14 calendar days and will send the member a written notice of determination within 10 calendar days of making a decision.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (A)*	7. Disenrollment at the Request of the MCO *The MCO may request disenrollment of a member if the continued enrollment of the member seriously impairs the MCO's ability to furnish service to either the particular member or other members.*	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67) **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	a) The MCO must confirm that the member has been referred to the MCO's Member Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem.	Anthem may request that a recipient be disenrolled for several reasons outlined on page 67 of the member handbook.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (C)(1-7)*	8. Reasons an MCO May Not Request Disenrollment The MCO may not request disenrollment of a member for any of the following reasons: a) An adverse change in the member's health status; b) A pre-existing medical condition; c) The member's utilization of medical services; d) Diminished mental capacity; e) Uncooperative or disruptive behavior resulting from his or her special needs (except when continued enrollment of such a member seriously impairs the MCO's ability to furnish services to either this particular member or other members); f) A member's attempt to exercise his or her grievance or appeal rights; or g) Based on the member's national origin creed, color, sex, religion, or age.	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67, 68) PP Member Request for Disenrollment-NV **Description of Process:** Anthem adheres to RFP 3260 §3.5.7.4(C) regarding "Disenrollment at the Request of the Vendor," as well as in accordance with 42 CFR 438.56. Anthem is prohibited from requesting any member's disenrollment for the reasons outlined in the above-referenced RFP. Consequently, the process to disenroll a member follows Anthem's Disenrollment Policy requiring the Quality Management Director to review all disenrollment requests, including internal Anthem requests to disenroll a member. This review ensures compliance	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		with both the RFP and federal law, while also ensuring consistency in Anthem's review and decision-making.	
	Findings: The MCO's Member Handbook included a section labeled *Other Information*, which had instructions for how the member could disenroll from Anthem. The handbook also included the reasons a member could be disenrolled by the MCO but did not contain the reasons that a member could not be disenrolled by the MCO. The Member Request for Disenrollment policy also had no mention of the reasons the MCO is not permitted to request disenrollment of a member. After the virtual review, the MCO provided its Involuntary Termination Initiated by Anthem NV desktop procedure, which met the intent of this requirement; however, the procedure document was not developed until August 14, 2020.		
	Required Actions: The MCO may not request disenrollment of a member for any of the reasons identified in federal and State regulations.		

Results for Standard XIV: Enrollment and Disenrollment							
Total Elements	Met	=	6	X	1.00	=	6.00
	Partially Met	=	1	X	.50	=	.50
	Not Met	=	1	X	.00	=	.00
	Not Applicable	=	0	X	.00	=	.00
	Total Applicable	=	8	**Total Rate**		=	6.50
Total Rate ÷ Total Applicable				**= Total Score**			**81%**

Instructions: For each element that required corrective action, provide evidence to support that the plans of action were completed and implemented.

State Fiscal Year (SFY) 2017–18 CAP Compliance Review

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**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	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

[B-1] The Information Submitted as Evidence by the MCO column was completed by the MCO and has not been altered by HSAG except for minor formatting.

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
		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.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Anthem is implementing an updated policy and procedure to address those individuals residing more than 25 miles away from a PCP. A report will be generated every month of members that reside more than 25 miles away from a PCP. The Quality Department will be sending letters for those members to sign and return acknowledging that they are more than 25 miles away from a PCP and wish to remain with their assigned PCP. If the letter is not returned, the Quality Department will make three phone call attempts and then a certified return receipt letter. Returned, signed letters will be logged into our system under the members account, and if no letter is received back after all of the outreach attempts, an unable to reach letter will be filed under the members account. This information will be tracked every month and reported to the State.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Standards and Measures for Appropriate Provider Availability, addressed the process, timeframes and responsible department for ensuring notification to those individuals residing more than 25 miles away from a PCP. The policy also described the process for contacting members in these situations to request that the member submit a letter acknowledging that they reside more than 25 miles away from a PCP and that they wish to remain with their assigned PCP. The CAP did not detail the person responsible for ensuring the policy is implemented or the proposed timeline for enacting the policy. Further, it is unclear if the MCO outreached to the six members that resided in Laughlin, which were found to be outside the contractually required 25-mile limit from the assigned PCP. **DHCFP Comment:** The policy is approved; however, Anthem must detail the person responsible for ensuring the policy is implemented and the proposed timeline for enacting the policy. Further, Anthem should update the DHCFP with the status of those six members which were found to be outside the contractually required 25-mile limit from the assigned PCP.		
Corrective Action Plan, Second Submission	Anthem's Provider Solutions Director will ensure the revisions to the policy are implemented and internally approved. The policy is set to be finalized prior to end of July 2018 and will be submitted to DHCFP once completed. Anthem has already begun implementing the process outlined in the policy. An updated report has been run identifying currently enrolled members who are assigned outside of the 25-mile limit. A Quality Management Member Liaison has made outreach calls to those identified active members. Members will be mailed a letter requesting their written consent acknowledging the distance to their assigned PCP. Please note that the six members identified in the Q3 2017 Geo Access report are no longer enrolled with Anthem.		
DHCFP Response (To be completed by DHCFP/HSAG.)	Anthem's policy, Standards and Measures for Appropriate Provider Availability is on schedule to be finalized prior to the end of July 2018 and will be submitted to DHCFP once finalized. The Provider Solutions Director is the staff responsible for ensuring the elements of the policy is implemented and internally approved. Anthem noted that the six members identified as residing outside the contractually required 25-mile limit from the assigned PCP are no longer enrolled with Anthem. Based on the information provided and supporting documentation, Anthem has addressed the deficiencies noted. **DHCFP Comment:** The revised CAP is approved.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
2020 CAP Compliance Review			

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

II PP Standard and Measures for Appropriate Provider Availability – NV
II Members Without 25 mi PCP Access November 2019
II NV Unable to Contact Ltr ANV-MEM-0293-18
Letter to member re 25 mile radius
2019 Q3 Managed Care Accessibility Access (II 2019 Q3_6B HSAG.pdf)
2019 Q4 Managed Care Accessibility Access (II 2019 Q4_6B HSAG.pdf)

Anthem implemented a policy and procedure to address individuals residing more than 25 miles away for their PCP (II PP Standard and Measures for Appropriate Provider Availability - NV.pdf, page 5). The Quality Team receives a monthly report identifying members that reside more than 25 miles from a PCP (II Members Without 25 mi PCP Access November 2019.xlsx). The Quality Department outreaches to each member listed on the monthly report to confirm their acceptance of the assignment or to assist with reassignment. If we are unable to contact the member after three attempts an unable to contact letter is mailed (II NV Unable to Contact Ltr ANV-MEM-0293-18.pdf). A sample letter is included for reference (II NV Unable to Contact Ltr_sample).

Please note that during the course of reviewing the process and documentation for the audit, it was identified that the initial letter called out in our Standards and Measures for Appropriate Provider Availability policy was not being mailed. The Quality team has been conducting the monthly outreach to each identified member to assist with PCP assignment and/or follow up on consent of the assignment. Upon implementation of the policy and process, the Quality team underwent significant staffing changes that resulted in the failure to initiate the mailing of the initial letters process. Attached you will find the draft initial letter (Letter to member re 25 mile radius) that will be going through both our internal and DHCFP approval process. We are working to resolve the issue, and will be monitoring it ongoing to ensure both the initial letter and follow up outreach is conducted.

HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.

Recommendations: Anthem staff reported both in the desk review documentation and during the review that the CAP for this element was not fully implemented until recently due to the health plan reorganization as well as changes in staffing and departmental responsibilities. The Anthem staff members explained the monitoring processes that have been implemented along with the health plan's strategy for increased monitoring of the mailing

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
of the initial letter to members requesting their written consent acknowledging the distance to their assigned PCP that is outside of the standard of 25 mile radius. Anthem did provide a letter sent to a member requesting the member's consent to receive care from their assigned PCP that was outside the established standard mile radius as part of the follow-up documentation received post review. HSAG recommends the MCO develop a process to ensure all CAPs are implemented in a timely manner.			
Required Actions: None.			☒ Met ☐ Not Met

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 ☐ N/A
	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 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.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	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.)	Anthem currently ensures all delegated agreements are prior approved by DHCFP. The agreements are submitted by the Anthem Regulatory Manager for DHCFP review and approval. Anthem uploaded the DHCFP subcontractor approval documentation to the HSAG FTP site on 5/17/18 and 5/22/18.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO provided documentation to support subcontractor approval by DHCFP; however, the documents were uploaded on May 17th and 22nd, which was after the required submission date of April 30, 2018. **DHCFP Comment:** The CAP and additional documentation are accepted. In the future, Anthem must follow instructions to submit documentation to support compliance by the required submission date.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

PP Delegate/Vendor Oversight and Management Program
PP Medicaid Subcontractor Due Diligence
DHCFP Approval - Anthem Vendor Filing Conduent (non delegated)
DHCFP Approval - Linkia LLC Delegated Credentialing Subcontract Submission

Anthem currently ensures agreements are prior approved by DHCFP. Agreements are submitted by the Anthem Regulatory/Compliance Manager to DHCFP for review and approval. Please find attached Delegate/Vendor Oversight and Management Program policy outlining the DHCFP prior approval requirement and DHCFP approval samples.

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

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 ☐ N/A
	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 (Include required action, responsible individual, and completion date.)	Anthem currently ensures all delegated agreements are prior approved by DHCFP. The agreements are submitted by the Anthem Regulatory Manager for DHCFP review and approval. Anthem uploaded the DHCFP subcontractor approval documentation to the HSAG FTP site on 5/17/18 and 5/22/18.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)	The MCO provided documentation to support subcontractor approval by DHCFP; however, the documents were uploaded on May 17th and 22nd, which was after the required submission date of April 30, 2018. **DHCFP Comment:** The CAP and additional documentation are accepted. In the future, Anthem must follow instructions to submit documentation to support compliance by the required submission date.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *PP Delegate/Vendor Oversight and Management Program* *PP Medicaid Subcontractor Due Diligence* *DHCFP Approval - Anthem Vendor Filing Conduent (non delegated)* *DHCFP Approval - Linkia LLC Delegated Credentialing Subcontract Submission* Anthem currently ensures all delegated agreements are prior approved by DHCFP. The agreements are submitted by the Anthem Regulatory/Compliance Manager for DHCFP review and approval. Please find attached Delegate/Vendor Oversight and Management Program policy outlining the DHCFP prior approval requirement and DHCFP approval samples.		
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

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 ☐ N/A
	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.)	Anthem's Medicaid Compliance Subcontractor Management Due Diligence policy defines the need for prior state approval as well as our Nevada Subcontractor Exhibit / State-Specific Requirements that are required as part of the vendor agreement. Medicaid Compliance Subcontractor Management Due Diligence Policy · Pg. 8, Section 4.3(b)(vi) · Pg. 9, Section 4.3(h) & (g) Nevada Subcontractor Exhibit · Pg. 4, Section 8 Anthem's Delegation Oversight department will update the Delegate/Vendor Oversight and Management Program policy to also include the DHCFP prior approval contract language in the exceptions section on page 22.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The Medicaid Compliance Subcontractor Management Due Diligence Policy described the provision to submit to the State agency the subcontractor agreement for any subcontractor. The Nevada Subcontractor Exhibit included the provision that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work performed without Anthem's written approval. **DHCFP Comment:** The CAP is approved; however, Anthem must provide DHCFP the completion date that the Delegate/Vendor Oversight and Management Program policy will be enacted.		
Corrective Action Plan, Second Submission	Anthem's Delegation Oversight department has updated the Delegate/Vendor Oversight and Management Program policy (draft attached) and is pending final approval from our Quality Improvement committee scheduled to meet on 8/9/18. Upon final internal approval the finalized policy will be submitted to DHCFP.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The updated Delegate/Vendor Oversight and Management Program policy submitted includes the DHCFP prior approval contract language and is pending final approval from Anthem's Quality Improvement committee that is scheduled to meet on August 9, 2018. Anthem will submit the finalized policy to DHCFP. Based on the information provided and supporting documentation, Anthem has addressed the deficiencies noted.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	DHCFP Comment: The revised CAP is approved.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *PP Delegate/Vendor Oversight and Management Program* *PP Medicaid Subcontractor Due Diligence* *DHCFP Approval - Anthem Vendor Filing Conduent (non delegated)* *DHCFP Approval - Linkia LLC Delegated Credentialing Subcontract Submission* Anthem currently ensures all delegated agreements are prior approved by DHCFP. The agreements are submitted by the Anthem Regulatory/Compliance Manager for DHCFP review and approval. Please find attached Delegate/Vendor Oversight and Management Program policy outlining the DHCFP prior approval requirement and DHCFP approval samples.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

SFY 2018–19 CAP Compliance Review

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.10(f)(5) *DHCFP Contract Section 3.6.3.4(B)*	5. Provider Terminations In cases where a PCP has been terminated, the MCO must notify enrolled recipients in writing and allow recipients to select another PCP or make a reassignment within 15 business days of the termination effective date, and must provide for urgent care for enrolled recipients until re-assignment.	**Documents Submitted:** VI.5Member Handbook 2018 English.pdf VI.5Member Notification PCP.pdf VI.5Member Notification.pdf VI.5NVNV_CAID_ProviderManual.pdf VI.5PCP Term Example.pdf VI.5PP Provider Terminations.pdf VI.5Provider Term Example 1.pdf VI.5Provider Term Example 2.pdf **Description of Process** If a PCP/PCS has been terminated, the health plan notifies enrolled members in writing within fifteen (15) days of receipt or issuance of the termination notice to each member who received primary care from the terminated provider. The health plan will provide for urgent care for the enrolled member until the reassignment of the new PCP is completed.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Primary Care Provider Selection, Assignment and Change Requests – NV procedure stipulated that Anthem will notify members in writing within 15 days of receipt or issuance of a termination notice to each member who received primary care from or was seen regularly by the terminating provider. The Primary Care Provider Selection, Assignment and Change Requests – NV procedure identified that Anthem will provide urgent care for the affected member until reassignment to a new PCP is completed. The termination template letter included the date of the letter, the effective date of the provider's		

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	termination, and instructions concerning how to select a new PCP through the Anthem website or by calling Anthem's member service representatives. However, the provider termination example provided by Anthem shows the letter of termination from the provider was dated September 13, 2018. Changes to Anthem's system were initiated on October 26, 2018, and completed on October 30, 2018, and it was unclear if written notice to the member was issued. Anthem staff members explained that the provider's termination letter was received during a site visit. As the assigned physician no longer practices under that clinic, the member was reassigned to another physician within the same clinic. While a new ID card was generated, written notice to the member was not issued.		
	Recommendations: In cases in which a PCP has been terminated from the health plan, Anthem must ensure written notice is provided to affected members within the required time frame.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Allyson Hoover Director Provider Solutions Internal Staff and interdepartmental education on the timeframe and outcomes of completing a service form for a terminated provider was completed in the 2Q 2019. Ongoing education of new staff to the department regarding member notification within 15 days has been implemented. Introductions and confirmation of steps has been provided to Anthems enrollment team. Quarterly look back quality checks to assure process is correct will take place at the end of each quarter.		
DHCFP Response (To be completed by DHCFP/HSAG.)	Based on the actions taken to educate and train existing staff, implementing training for new staff, and quarterly monitoring activities, Anthem has addressed the deficiencies noted for Standard VI, element 5. The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *VI PP Primary Care Provider Termination and Member Notification Service Form Process (pg.5)* *VI NV PCP Gone Letter ENG FINAL*			

Standard VI: Member Rights and Responsibilities			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
VI NV PCP Leaving w Advance Notice Ltr *VI Provider Term Example Arce Joanne* Please find the attached member notices that are sent when a PCP is terminating. The VI NV PCP Leaving w Advance Notice Ltr is sent when a PCP decides to leave the network; and VI NV PCP Gone Letter ENG FINAL is sent when Anthem terminates a PCP. Also for reference is a sample provider termination as well as our Provider Termination Member Reassignment Service Form Process policy.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.402(c)(3) *DHCFP Contract Section 3.13.2.7*	11. Appeals Accepted Orally or in Writing A recipient, or a provider acting on behalf of the recipient, may file an appeal or grievance either orally or in writing. a. Unless the recipient has requested an expedited resolution, an oral appeal may be followed by a written, signed appeal. b. If a grievance or appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. c. There is no requirement to track routine telephone inquiries.	**Documents Submitted:** IX.11Member Handbook 2018 ENG.pdf IX.11Member Handbook 2018 SPN.pdf IX.11NV Member Request for Appeal Review Form ENG.pdf IX.11NV Member Request for Appeal Review Form SPN.pdf IX.11NVNV_CAID_ProviderManual.pdf IX.11PP Administrative Denial Appeal Process.pdf IX.11PP Medical Necessity Appeals.pdf IX.11PP Member Grievance Resolution.pdf IX.11PP State Fair hearing.pdf IX.11Verbal Appeal Acknowledgement Letter ENG.pdf IX.11 Verbal Appeal Acknowledgement Letter SPN.pdf IX.11NV Member Denial Letter_pg_7_8_9.pdf **Description of Process:** Member Denial Letter informs the member that they can ask for an appeal by calling 1-844-396-2329 or by submitting a request in writing to Central Appeals Processing, Anthem Blue Cross and Blue Shield Healthcare Solutions, PO box 62429, Virginia Beach, VA 23466-2429.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The policy, Medical Necessity Appeals, described the process for members to file an appeal orally or in writing and following an oral appeal with a written, signed appeal. The policy also described Anthem's process for documenting receipt of an oral appeal to establish the earliest possible filing date. The policy included that "an oral appeal must be followed by a written request within 10 calendar days unless requesting an expedited appeal." In addition, the policy included language that the appeal would be closed if the written request was not received within 10 calendar days. This procedure is not compliant with the federal language, wherein page 27511 of the preamble includes: We also disagree with the commenter that recommended that all oral appeals be closed within 10 calendar days if no written or signed follow-up is received. This is not consistent with our general approach to allow enrollees to submit appeals orally and in writing. Managed care plans should treat oral appeals in the same manner as written appeals. Anthem staff members confirmed that the 10-day requirement to submit a written appeal after filing an oral appeal or the appeal will be closed is inconsistent with federal regulations. Staff members also confirmed that the policy was currently under revision and that this provision would be updated to be consistent with the federal language and its intent.		
	Recommendations: Anthem must ensure that standard oral appeals are treated as written appeals to establish the earliest possible file date and to ensure processing occurs according to the required time frames.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Monica Bender Director Grievance and Appeals The "Medical Necessity Appeals" Policy was updated to reflect the above recommendation identifying oral appeals to be treated as written appeals and to be processed according to the required time frames. A job aide was created and internal staff education/training was completed on 5/22/19. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Medical Necessity Appeals-NV, revised on May 21, 2019 provided evidence that the MCO deleted the provision, "an oral appeal must be followed by a written request within 10 calendar days unless requesting an expedited appeal." Anthem confirmed that staff member training regarding the revised policy occurred on May 22, 2019. The DHCFP approves this CAP.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *Medical Necessity Appeals – NV* *NV Appeal Process Job Aide* See page 5, Section 2 under Filing an Appeal of attached Medical Necessity Appeals policy identifying current process in compliance with previous updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.210(d)(2)(i-ii) *42 CFR §438.404(c)(4)(i)* *42 CFR §438.408(b)(3)* *42 CFR §438.408(c)(1)(i-ii)* *DHCFP Contract Section 3.13.3.2*	15. Expedited Authorization Decisions For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide a notice of action as expeditiously as the recipient's health condition warrants and no later than 72 hours after receipt of the request for service. The MCO may extend the 72 hours' time period by up to 14 calendar days if the recipient requests an extension or if the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's interest. The MCO must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.	**Documents Submitted:** IX.15PP Concurrent Review Core Process.pdf IX.15PP Health Care Management Denial Core Process.pdf IX.15PP Medical Necessity Appeals.pdf IX.15PP Member Grievance Resolution.pdf IX.15PP Member Rights and Responsibilities.pdf IX.15PP Pre-Certification of Requested Services Core Process.pdf IX.15PP State Fair Hearing.pdf IX.15PP Pharmacy Prior Authorization_pg_3_bullet_10_11.pdf **Description of Process:** Anthem's standard for prior authorization coverage requests is for them to be processed within 24-hours of receipt for Pharmacy.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, Pre-Certification of Requested Services Core Process, provided evidence of the MCO's policy to provide expedited authorization decisions within the time frames and parameters specified in this element. The policy did not include the provision that when additional time is needed to make an expedited decision, the MCO provides notice to the member with the reason for the extension and informs the member of the right to file a grievance. This language was included to extend standard authorization decisions, but it was not included to extend expedited authorization decisions. Anthem staff members stated that they make all expedited decisions within the required time frames, but that the language to extend the expedited decision and provide notice of the extension and the member's right to file an appeal was not included in the policy.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: Anthem must ensure that its grievance process includes the provision that if the MCO extends the 72-hour time period to make a decision by up to 14 calendar days, if the recipient requests an extension or if the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's interest, the MCO must provide written notice of the reason for the extension and inform the recipient of the right to file a grievance.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Cindy Bradshaw Dir Healthcare Management The "Pre-Certification of Requested Services Core Process" Policy was updated to reflect the above recommendation and a draft was sent for committee urgent approval. Additionally, please find the attached letter template for UM TAT Extension (NVUM0022), which provides grievance/appeals information if the member does not agree with the decision to extend TAT. Education will be provided to all Precert UM clinical and non-clinical staff by August 15, 2019. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Pre-Certification of Requested Services Core Process, revised on July 5, 2019 contained the following revised language, "If the Health Plan has extended the time frame for an authorization decision in accordance with DHCFP Contract Section 3.13.3.2, the Health Plan is required to give the member written notice of the reason for the decision to extend the time frame with information on the right to file an **appeal** if the member disagrees with that decision." Although the revision contains most of the information that is written in the federal regulations related to extending the timeframes for standard authorization decisions, the revision to give notice to the member of their right to file an **appeal** if they disagree with the MCO's decision to extend the timeframe for an authorization decision, is inappropriate and inconsistent with the federal regulations. Since this element pertains to standard authorization requests and the MCO's allowance to extend the timeframe to make a standard authorization decision, it is assumed that no authorization decision has been rendered; therefore, there is no decision that can be appealed by the member. Instead, the only recourse the member has if they disagree with extending the timeframe to authorize a service is to grieve the MCO's decision to extend the timeframe to authorize the service. The DHCFP rejects this CAP and requires the MCO to resubmit a CAP in response to this element.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	Cindy Bradshaw Dir Healthcare Management The "Pre-Certification of Requested Services Core Process" Policy was updated to reflect the above recommendation and a corrected version was sent for committee urgent approval, noting the change in language from 'appeal' to 'grievance'. This was an oversight. Additionally, please find the attached letter template for UM TAT Extension (NVUM0022), which provides grievance information if the member wants to grieve the MCO's decision to extend TAT. Education was provided to all Precert UM clinical and non-clinical staff on August 15, 2019, and this correction will be noted and disseminated to those trained. The revised policy is attached for reference noting the correction on page 31.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The revised Pre-Certification of Requested Services Core Process policy provided evidence that staff members updated the language in the Nevada-specific section of the policy to read, "If the Health Plan has extended the time frame for an authorization decision in accordance with DHCFP Contract Section 3.13.3.2, the Health Plan is required to give the member written notice of the reason for the decision to extend the time frame with information on the right to file a grievance if the member disagrees with that decision." This revision to the Nevada section of the policy is acceptable and DHCFP approves the CAP. Anthem should note, however, page 24 of the revised policy contains similar language that applies to the Iowa market. Anthem should consider modifying the language so that it is consistent with the federal regulations. Currently, the language reads as Nevada's language read, that a member may file an appeal if he/she disagreed with the MCOs option to extend an authorization decision. As noted in the DHCFP's response to Anthem's first CAP, this language is inconsistent with the federal requirements. Anthem should consider a company-wide retraining of staff members for all markets to ensure they understand the provisions for Medicaid managed care that are outlined in the Code of Federal Regulations Title 42 Part 438, and more specifically, staff members should be trained on the intent and application of those provisions. Based on the inconsistencies noted in the policies, it is unclear if Anthem staff members truly understand the intent of the regulations and applicability to Medicaid managed care.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *PP Pre-Certification of Requested Services Core Process policy* See page 36 of the Pre-Certification of Requested Services Core Process policy identifying current process in compliance with previous updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.404(b)(1-6) *42 CFR §438.404(c)(1)* *42 CFR §438.408(e)(1)* *42 CFR §438.408(e)(2)(i-iii)* *42 CFR §438.420(a)(1)* *DHCFP Contract Section 3.13.4.3 (A-J), 3.13.4.4, 3.13.5.6 (A-C)*	18. Requirements of a Written Notice of Action A written notice of action to the recipient meets the following requirements and explains: a. The action the MCO or its subcontractor has taken or intends to take; b. The reasons for the action; c. The recipient's or the provider's right to file an appeal, if he/she disagrees with decision; d. The recipient's right to request a State Fair Hearing after the recipient has exhausted the MCO's internal appeal procedures; e. The procedures for exercising the recipient's rights to appeal; f. The circumstances under which expedited resolution is available and how to request it; g. The recipient's rights to have benefits continue if the appeal is filed on or before the latter of the following: within 10 calendar days of the MCO mailing the Notice of Action or the intended effective date or the proposed action pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the recipient may be required to pay the costs of these services; h. That the recipient may represent himself or use legal counsel, a relative, a friend, or other spokesman;	**Documents Submitted:** IX.18Member Handbook 2018 ENG.pdf IX.18Member Handbook 2018 SPN.pdf IX.18NV Mbr-Prov Initial Denial Lttr ENG.pdf IX.18NV Mbr-Prov Initial Denial Lttr SPN.pdf IX.18PP Health Care Management Denial Core Process.pdf IX.18PP Medical Necessity Appeals.pdf IX.18PP Member Grievance Resolution.pdf IX.18PPMember Materials Appropriateness.pdf IX.18PP Member Rights and Responsibilities.pdf IX.18PP Oral Translation Interpretation Services.pdf **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	i. The specific regulations that support, or the change in federal or State law that requires the action; j. The recipient's right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of action based on change in law, the circumstances under which a hearing is granted; and, k. The MCO gives notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five days if probable recipient fraud has been verified.		
	Findings: The policy, Health Care Management Denial Core Process, defined the procedures to provide written notice of action to members and providers as outlined in a through j of this element. The provision in sub-element k was not contained in the policy. Anthem staff members stated that if the MCO staff members authorize a service, staff members will not later reduce, suspend, or terminate the service. When a member transfers with an open authorization from a different MCO, staff members stated that they allow the open authorization to stand for a minimum of 30 days until it undergoes concurrent review. During the on-site review, the HSAG interviewer asked the question, "If concurrent review determines that the service should be reduced, suspended, or terminated, how do you ensure that the notice to reduce, suspend, or terminate the service to the member is sent at least 10 days before the date of action?" Staff members confirmed that the policy did not contain the required language and that the policy would need to be revised.		
	Recommendations: Anthem must ensure that it gives notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This time frame may be shortened to five days if probable recipient fraud has been verified.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Cindy Bradshaw Director Healthcare Management The "Healthcare Management Denial Core Process" Policy was updated to reflect the above recommendation and a draft was sent for committee urgent approval. Education will be provided to all Precert UM clinical and non-clinical staff by August 15, 2019. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Pre-Certification of Requested Services Core Process-Update (003), revised on July 5, 2019 contained the following provision, "If the Health Plan intends to take an action to terminate, suspend, or reduce previously authorized Medicaid-covered services, the Health Plan shall give notice of the adverse action at least ten (10) days before the date of action. This time frame may be shortened to five days if probable recipient fraud has been verified." The CAP also included the action to train non-clinical staff members on the revised policy by August 15, 2019. The DHCFP approves this CAP once the MCO confirms and provides evidence that staff training regarding the revised policy was completed. Evidence of staff training on the revised policy received on 9/9/19. The DHCFP approves this CAP.		

2020 CAP Compliance Review

MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.*

PP Pre-Certification of Requested Services Core Process
PP Healthcare Management Denial Core Process

See page 37 of the Pre-Certification of Requested Services Core Process policy and page 33 of the Healthcare Management Denial Core Process policy identifying current process in compliance with previous updates.

HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.404(c) *DHCFP Contract Section 3.13.4.5(A-H), 3.13.4.6 and 3.13.4.7*	19. Timing of the Notice of Action The MCO gives notice by the date of the action for the following circumstances: a. In the death of the recipient; b. A signed written recipient statement requesting termination or giving information requiring termination or reduction of services (where the recipient understands that this must be the result of supplying that information); c. The recipient's admission to an institution where he is ineligible for further services; d. The recipient's address is unknown and mail directed to him has no forwarding address; e. The recipient has been accepted for Medicaid services by another local jurisdiction; f. The recipient's physician prescribes the change in level of medical care; g. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or h. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers);	**Documents Submitted:** IX.19HHS Final Rule Notice Update SPN FINAL.pdf IX.19Member Handbook 2018 ENG.pdf IX.19Member Handbook 2019 SPN.pdf IX.19NV UM Letter Changes1.pdf IX.19NV UM Letter Changes2.pdf IX.19PP Administrative Denial Appeal Process.pdf IX.19PP Health Care management Denial Core Process.pdf IX.19PP Medical Necessity Appeals.pdf IX.19PP Quality of Care Core Procedure.pdf IX.19QM State Fair Hearing Form.pdf IX.19RBD HHS Final Rule Notice Update ENG FINAL.pdf IX.19PP Pharmacy Prior Authorization_pg3_bullet_8_9.pdf **Description of Process:** Pharmacy coverage denial letters are generated and faxed to a provider within 24 hours of the decision.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	i. The MCO must give a notice of action on the date of action when the action is a denial of payment; and, j. The MCO must give notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations; and k. Untimely service authorizations constitute a denial and are thus adverse actions.		
	Findings: The policy, Health Care Management Denial Core Process, defined the time frames to provide written notice of action to members and providers as outlined in a through i of this element. Sub-elements j and k were not contained in the policy. Anthem staff members confirmed that the policy did not contain the provisions outlined in j and k and would revise the policy to reflect the appropriate language.		
	Recommendations: Anthem must ensure that its authorization procedures include (j) providing a notice of action on the date that the time frames expire when service authorization decisions are not reached within the time frames for either standard or expedited service authorizations, and (k) untimely service authorizations constitute a denial and are thus adverse actions.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Cindy Bradshaw Director Healthcare Management The "Healthcare Management Denial Core Process" Policy was updated to reflect the above recommendation and a draft was sent for committee urgent approval. Education will be provided to all Precert UM clinical and non-clinical staff by August 15, 2019. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Pre-Certification of Requested Services Core Process-Update (003), revised on July 5, 2019 contained the following provision, "If Health Plan fails to provide a notice of action on or before the date that the time frames expire for either standard or expedited service authorization request, this will constitute a denial and thus issue an adverse action notice." The CAP also included the action to train non-clinical staff members on the revised policy by August 15, 2019.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The DHCFP approves this CAP once the MCO confirms and provides evidence that staff training regarding the revised policy was completed.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *PP Healthcare Management Denial Core Process* See page 33 of the Healthcare Management Denial Core Process policy identifying current process in compliance with previous updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.408(b)(1-3) *42 CFR §438.408(d)(1)* *42 CFR §438.408(d)(2)(i)* *DHCFP Contract Section 3.13.5–3.13.5.3*	20. Handling of Grievances and Appeals The MCO is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the recipient's health condition requires within the State's established time frames specified as follows: a. Standard disposition of grievances: The MCO is allowed no more than 90 calendar days from the date of receipt of the grievance. b. Standard resolution of appeals: The MCO is allowed no more than 30 calendar days from the date of receipt of the appeal. c. Expedited resolution of appeals: The MCO must resolve each expedited appeal and provide notice, as expeditiously as the recipient's health condition requires, not to exceed 72 hours after the MCO receives the expedited appeal request.	**Documents Submitted:** IX.20Member Handbook 2018 ENG.pdf IX.20Member Handbook 2018 SPN.pdf IX.20PP Administrative Denial Appeal Process.pdf IX.20PP Medical Necessity Appeals.pdf IX.20PP Member Complaints Grievances.pdf IX.20PP Member Grievance Resolution.pdf IX.21NV Member Denial Letter_pg_7.pdf **Description of Process:** Anthem meets or provides disposition of grievances in 90 days or less from the receipt of the grievance. Anthem's timeliness and notification standards consider clinical urgency and provides a resolution in accordance with regulatory state, federal, and accreditation standards, including NCQA. The expedited appeal process shall resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within state established time frames not to exceed seventy-two (72) hours after the Health Plan receives the appeal request, whether the appeal was made orally or in writing. The Health Plan shall ensure that no punitive action is taken against a provider who requests or supports a request for an expedited appeal. If the Health Plan denies the request for expedited appeal, it shall immediately transfer the appeal to	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		the timeframe for standard resolution and so notify the enrollee.	
	Findings: The policy, Medical Necessity Appeals, defined the time frames to resolve standard and expedited appeals; however the policy contained the following, "Appeal decisions must be in writing and resolved as expeditiously as the member's health condition requires, but not to exceed the following time frames: Expedited appeals: As expeditiously as the member's medical condition requires, but no later than three (3) working days from the date of receipt of the appeal." This language is inconsistent with the 72-hour resolution requirement for expedited appeals. Anthem staff members confirmed that the language in the policy was inconsistent with the requirement and would revise the policy to reflect the appropriate time frames.		
	Recommendations: Anthem must ensure that expedited appeals are resolved as expeditiously as the member's medical condition requires, but no later than 72 hours from the date of receipt of the request for expedited appeal.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Monica Bender Director Grievance and Appeals The "Medical Necessity Appeals" and "State Fair Hearing" Policies have been updated to reflect the 72 hour requirement time frame. Internal staff education/training was completed on 5/22/19. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Medical Necessity Appeals-NV, revised on May 21, 2019 contained provisions for processing expedited appeals. Paragraph 2 of the Expedited appeals section of the policy contained the provision that expedited appeals will be reviewed and verbal communication of the decision would be made to the requestor within 72 hours of the time the expedited appeal request was received. Paragraph 5 of the same policy section contained the following, "In the event the expedited appeal decision upholds the denial of, or reduction, suspension, or termination of a previously approved medical care, the member/provider must be notified immediately verbally and the health plan must send written documentation of the denial within three (3) calendar days." It is possible that the 3-calendar day timeframe could extend beyond 72 hours; therefore, the language in the policy is still out of compliance with the federal regulation that expedited appeals are resolved as expeditiously as the member's medical condition requires, but no later than 72 hours from the date of receipt of the request for expedited appeal.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The DHCFP rejects this CAP and requires the MCO to resubmit a CAP in response to this element.		
Revised Corrective Action Plan (Include required action, responsible individual, and completion date.)	Monica Bender Director Grievance and Appeals The "Medical Necessity Appeals" policy has been updated to reflect all references to the 72 hour requirement time frame. The revised policy is attached for reference noting the correction on page 6.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Medical Necessity Appeals, provided evidence that language was revised to include the 72-hour requirement. The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *Medical Necessity Appeals - NV* See Page 4, Section 12 under Procedures and Page 6, Section 5 under Expedited Appeals of the attached Medical Necessity Appeals policy identifying current process in compliance with previous updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.406(b)(1-3) *42 CFR §438.406(b)(4-6)* *DHCFP Contract Section 3.13.5.5(A-D)*	24. Process for Appeals The process for appeals also requires: a. That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the recipient requests expedited resolution; b. That the recipient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that the recipient is informed by the MCO of the limited time available for this in the case of expedited resolution; c. That the recipient and his/her representative is provided the opportunity, before and during the appeals process, to examine the recipient's case file, including medical records, and any other document and records considered during the appeals process; and d. Include, as parties to the appeal, the recipient and his/her representative or the legal representative of a deceased recipient's estate.	**Documents Submitted:** IX.24Member Handbook 2018 ENG.pdf IX.24Member Handbook 2018 SPN.pdf IX.24NV Mbr-Prov Initial Denial Lttr ENG.pdf IX.24NV Member Grievance 1st Acknowledgement Letter_ENG.pdf IX.24NV member Grievance 1st Acknowledgement Letter_SPAN.pdf IX.24NV Member Request for Appeal Review Form ENG.pdf IX.24NV Member Request for Appeal Review Form SPN.pdf IX.NV Member Denial Letter_pg_7.pdf IX.24PP Medical Necessity Appeals.pdf IX.24PP Member Grievance Resolution.pdf IX.24PP Provider Grievance Process Utilizing Beacon or NART.pdf **Description of Process:** Our appeals process accepts both oral and written requests to appeal a denial of service. The member is provided a reasonable opportunity to present facts in support of their request. Standard appeals shall be resolved and notice sent to the member no later than 30 calendar days from our receipt of the appeal request.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The policy, Medical Necessity Appeals, described the procedures to process appeals and contained the provisions outlined in b through d of this element. For provision a, the policy included that, "an oral appeal must be followed by a written request within 10 calendar days unless requesting an expedited appeal." In addition, the policy included that the appeal would be closed if the written request was not received within 10 calendar days. This procedure is not compliant with the federal language, wherein page 27511 of the preamble includes: We also disagree with the commenter that recommended that all oral appeals be closed within 10 calendar days if no written or signed follow-up is received. This is not consistent with our general approach to allow enrollees to submit appeals orally and in writing. Managed care plans should treat oral appeals in the same manner as written appeals. Anthem staff members confirmed that the 10-day requirement to submit a written appeal after filing an oral appeal or the appeal will be closed is inconsistent with the federal regulations. Staff members also confirmed that the policy was currently under revision and that this provision would be updated to be consistent with the federal language and its intent.		
	Recommendations: Anthem must ensure that standard oral appeals are treated as written appeals to establish the earliest possible file date and to ensure processing occurs according to the required time frames.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Monica Bender Director Grievance and Appeals The "Medical Necessity Appeals" Policy was updated to reflect the above recommendation identifying oral appeals to be treated as written appeals and to be processed according to the required time frames. A job aide was created and internal staff education/training was completed on 5/22/19. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Medical Necessity Appeals-NV, revised on May 21, 2019 provided evidence that the MCO deleted the provision, "an oral appeal must be followed by a written request within 10 calendar days unless requesting an expedited appeal." The policy also included the provision that the date the oral appeal was filed would be used to determine the date of receipt of the appeal to establish the earliest possible filing date. Anthem confirmed that staff member training regarding the revised policy occurred on May 22, 2019. The DHCFP approves this CAP.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *Medical Necessity Appeals – NV* See page 5, Sections 2 and 3 under Filing an Appeal of the attached Medical Necessity Appeals policy identifying current process in compliance with previous updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.424(a-b) *DHCFP Contract Section 3.13.7.4*	33. Reversing and Action to Deny, Limit, or Delay Services If the MCO or Fair Hearing Officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination.) If the MCO or State Fair Hearing Officer reverses a decision to deny authorization of services, and the recipient received the disputed services while the appeal was pending, the MCO or the State pays for those services in accordance with State policy and regulations.	**Documents Submitted:** IX.33Member Appeal Upheld Partial_ENG.pdf IX.33Member Appeal Upheld Partial_SPAN.pdf IX.33Member Handbook 2018 ENG.pdf IX.33Member Handbook 2018 SPN.pdf IX.33NVNV_CAID_ProviderManual.pdf IX.33PP Medical Necessity Appeals.pdf IX.33PP Member Grievance Resolution.pdf **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, State Fair Hearing, included the provisions related to State fair hearings and reversing the action to deny, limit, or delay services. The policy contained the provision that if the MCO or fair hearing officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires. The policy did not stipulate, however, that services must be provided no later than 72 hours from the date of receipt of the notice reversing the determination. Anthem staff members confirmed that the language was not included in the policy and that they will update the policy to reflect the language.		
	Recommendations: The MCO must ensure that if the MCO or fair hearing officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Monica Bender Director Grievance and Appeals The "State Fair Hearing" Policy has been updated to reflect the above recommendation identifying action reversal requirements and time frames. Internal staff education/training was completed on 5/22/19. Revised policies are attached for reference.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, State Fair Hearing, revised on May 21, 2019 included the provision that if the MCO or fair hearing officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Anthem confirmed that staff members received training on the revised policy on May 22, 2019. The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* *Medical Necessity Appeals – NV* See Pages 8 and 9, Sections 6 under State Fair Hearing, and Sections 6 and 7 under Provider State Fair Hearing of the attached Medical Necessity Appeals policy identifying current process in compliance with previous updates.			
HSAG Findings: HSAG has determined that the MCO demonstrated that the CAP for this element was fully implemented.			
Required Actions: None.			☒ Met ☐ Not Met

SFY 2019–20 Compliance With Standards Review Tool CAP Template

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
42 CFR §438.330(d)(3) *DHCFP Contract Section 3.10.7.5*	9. Implementation of PIPs The MCO is required to report the status and results of each project to DHCFP as requested, but not less than once per year. *a) The MCO is required to annually conduct and report on a minimum of two clinical PIPs and three non-clinical PIPs.* *b) Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.*	**Documents Submitted:** 1. Follow Up after ER Discharge (FUM) RCI PIP (FUM.zip - Module submissions and validation feedback for each module); 2. Well-Child Visits for Children 3 to 6 Years of Age (W34) RCI PIP (W34.zip - Module submissions and validation feedback for each module) **Description of Process:** In accordance with RFP provisions, and HSAG requirements, Anthem produces PIP modules at the determined intervals. Anthem participates in monthly PIP Technical Assistance Meetings with HSAG, and submits each module for each PIP in accordance with the schedule outlined by HSAG.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: While the MCO worked with HSAG to conduct and validate two State-required PIPs, MCO staff members were unable to confirm they had engaged in any other PIPs. After the virtual review, the MCO submitted an emergency (ED)		

[C-1] The Information Submitted as Evidence by the MCO column was completed by the MCO and has not been altered by HSAG except for minor formatting.

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	department follow-up PIP report; however, it did not appear that the MCO's methodology for a PIP was followed and/or documented. **Recommendations:** HSAG strongly recommends that the MCO adhere to CMS EQR *Protocol 8. Implementation of Additional Performance Improvement Projects: An Optional EQR-Related Activity, October 2019* when conducting PIPs and ensure this is appropriately documented. All PIPs should be clearly identified and incorporated into the MCO's IQAP. Additionally, as the MCO is specifically required to conduct two clinical and three non-clinical PIPs annually, HSAG recommends that the MCO clearly identify in its IQAP the clinical and/or non-clinical focus of each PIP to ensure adherence to the requirements of this element.		
	Required Actions: The MCO must annually conduct and report on a minimum of two clinical PIPs and three non-clinical PIPs.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Lisa Werlech, Director of Quality Management Anthem will comply with the following: 1. Conduct and report on two clinical PIPs and three non-clinical PIPs; 2. Utilize CMS EQR *Protocol 8. Implementation of Additional Performance Improvement Projects: An Optional EQR-Related Activity, October 2019* when conducting PIPs and will follow the CMS Performance Improvement Plan – Worksheet (template can be submitted upon request). 3. Entitle each PIP to clearly identify the topic of the PIP and whether it is a clinical or non-clinical PIP; 4. Each clinical and non-clinical PIP will be clearly identified and incorporated into Anthem's IQAP annual documents: • *Quality Management Program Description* – The purpose of each PIP will be outlined and explained in the *2021 Quality Management Program Description*. • *Quality Management Work Plan* - each PIP will be clearly noted in the 2021 *Quality Management Work Plan* with anticipated milestones outlined. • *Quality Management Program Evaluation* – the progress and/or outcome of each PIP will be summarized in the *2020 Quality Management Program Evaluation.* • Medical Advisory Committee (MAC) - each PIP will be presented annually at Anthem's MAC for review, feedback, and approval.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	Completion Date: Non-clinical PIPs that were initiated in January 2020 will conclude in March 2021 (due to the need for three months of claims run-out).		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
DHCFP Contract Section 3.10.8.4, 3.10.8.5 (A-F)	12. Implementation of Corrective Actions *The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include:* *a) Specification of the types of problems requiring corrective action.* *b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems.* *c) Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff.* *d) The schedule and accountability for implementing corrective actions.* *e) The approach to modifying the corrective action if improvements do not occur.*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** a)-f), An evaluation of the QM Program is conducted on an annual basis. A critical part of this evaluation includes review and identification of quality initiatives that did not meet their goal, identification and analysis of issues or barriers to achieving goals, as well as recommended intervention or action to demonstrate improvement for the upcoming year. The evaluation and findings are presented to the MAC and QMC for leadership and provider input and recommendation. This also applies to Peer Review activities related to Credentialing/Recredentialing, as well as Delegation Oversight. Please see attached 2019 QM Program Description with corresponding bookmark labeled XI 12 a-f – Implementation of Corrective Actions with sub-bookmarks.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	f) Procedures for terminating the affiliation with the physician, or other health professional or provider.		
	Findings: The Quality of Care—Core Procedure and Peer Review—NV policy included provisions as required by this element except for sub-element (e), which was not well defined. These policies lacked specificity related to the MCO's approach to: • Modify corrective actions if improvements do not occur. • Monitor and evaluate plans of action to assure required changes have been made. • Monitor changes in practice patterns. • Timely follow-up on identified issues to ensure actions for improvement have been effective. MCO staff members indicated that this monitoring would occur, on a case-by-case basis (for example, setting up a calendar to monitor progress); however, there is an area of opportunity for the MCO to clarify, in policy, expectations that specifically address the above provisions to ensure adherence to the contract requirements. **Recommendations:** HSAG recommends that the MCO consider a standardized format for documenting all activities conducted to monitor and evaluate the corrective action to assure required changes have been made; monitor changes in practice patterns; assure timely follow-up on identified issues to ensure actions for improvement have been effective; and modify the corrective action if improvements do not occur.		
	Required Actions: The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include: • The approach to modifying the corrective action if improvements do not occur. The MCO must also: • Monitor and evaluate the plans of correction (POC) to assure required changes have been made. • Monitor changes in practice patterns. • Assure timely follow-up on identified issues to ensure actions for improvement have been effective.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Angela Oharrow, Manager Clinical Quality Anthem will update its Quality of Care and Peer Review policies and has created a standardized form to document all activities related to a remedial or disciplinary action plan assigned to a provider by the Peer Review Committee (PRC) as suggested. Policy updates to include: • Medical Director or designee will monitor Remedial or Disciplinary actions using a standardized form for documenting all activities related to remedial or disciplinary action as determined by PRC to assure required changes are made by specified date. • Medical Director or designee will evaluate Remedial or Disciplinary action plans through monitoring of quarterly provider trend reporting to ensure actions for improvement have been effective. • If remedial or disciplinary actions determined by the PRC indicate no improvement, the medical director or designee will review and present findings to the PRC for modifications as needed. • Modified remedial or disciplinary actions will be communicated by the medical director in writing by certified mail no greater than fourteen (14) calendar days from PRC determination for modifications. • If PRC remedial or disciplinary actions have not been implemented by established date or no response received from the provider, the Medical Director or designee will follow up with the PRC for next steps. Completion Date: December 31, 2020		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. The MCO must submit the updated policy to DHCFP to be reviewed and approved by the DHCFP prior to the policy being finalized. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
DHCFP Contract Section 3.10.9.6	16. Program Modification *Upon receipt of regular written reports delineating actions taken and improvements made, the Governing Body must take action when appropriate, and direct that the operational IQAP be modified on an ongoing basis to*	**Documents Submitted:** NV 2019-06-21 BOD Minutes **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	accommodate review findings and issues of concern with the MCO. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.	The Nevada Board annually reviews and approves the written QM Program Description, QM Work Plan, and the QM Program Evaluation. In the last evaluation period, calendar year 2019, the Board approved the action plans developed for 2020 with no revisions or requests for modifications. Please see attached NV BOD minutes labeled, "NV 2019-06-21 BOD Minutes".	
	Findings: Documentation did not support that the MCO provided regular written reports to the BOD outside of the annual IQAP review. MCO staff members explained that IQAP reporting occurs annually, while it used to occur quarterly.		
	Required Actions: The MCO must provide the BOD with regular written reports delineating actions taken and improvements made by the IQAP. The BOD must take action when appropriate, and direct that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO. This activity must be documented in the minutes of the meetings of the BOD in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Party: Lisa Werlech, Director of Quality Management We will continue the existing annual Board of Directors meeting to ensure IQAP discussion and ensure that any recommended actions are clearly documented in the minutes. Anthem will initiate an additional written report to the Board of Directors related to any IQAP actions taken and improvements made, and include a request for review of those materials by the Board. Thus, engagement of the Board will shift to twice yearly (once through the annual meeting and one additional written report). In the event of review findings and related concerns regarding the quality process, those findings and concerns shall be considered by the Board to determine what actions, or modifications to documents, if any, are appropriate to address the review findings. Board input and any resulting actions or improvements will be clearly documented by Quality Management. Note that two of four members of the Board are also active participants in Anthem's local Nevada Quality Management Committee which provides oversight of the IQAP. Completion Date: IQAP report frequency to the Board will increase to twice yearly starting in 2021.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
DHCFP Contract Section 3.10.10	17. Active QA Committee *The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the MCO. This committee or other structure must have:* *a) The structure/committee must meet on a regular basis with a specified frequency, no less than quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* *b) The role, structure and function of the structure/committee must be specified.* *c) There must be records documenting the structure and committee's activities, findings, recommendations and actions.* *d) IQAP subcommittees must be accountable to the Governing Body and must report to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.*	**Documents Submitted:** 2019 QM Program Description **Description of Process:** a. The Quality Management Committee meets, at a minimum, four times per year. In calendar year 2019, the QMC met this requirement and met six times. Additional Ad hoc meetings we also held during 2019. Please see the attached 2019 QM Program Description with corresponding bookmark labeled, "XI 17s – Quality Committee Structure". b. Please see the attached 2019 QM Program Description with bookmark labeled, "XI 17b – Purpose and Responsibilities". c. Meeting activity is recorded in minutes. Please see the attached 2019 QM Program Description with corresponding bookmark labeled, "XI 17c – Committee Minutes".	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	e) There must be active participation in the IQAP committee from MCO providers, who are representative of the composition of the MCO's providers.	d. QM Sub-Committees are accountable for reporting to the QMC. Please see attached 2019 QM Program Description for an example of a sub-committee and its reporting structure/accountability. Bookmark labeled, "XI 17d – QM Sub-Committee Example". e. There is active participation by health plan Medical and Behavioral Health Medical Directors, as well as practitioners from the community. Please see attached 2019 QM Program Description with corresponding book marks, XI 17e – MCO Provider Participation" and "Participating Practitioners".	
	Findings: The MCO demonstrated limited participation of network providers in the IQAP (and IQAP committee) outside of the Medical Advisory Committee (MAC). While the MAC reports to the Quality Management Committee (QMC), no QMC meeting minutes were provided to confirm adequate reporting and communication between the MAC and QMC. Additionally, while MCO staff members explained they also solicited input from the provider network through the Joint Consumer and Provider Advisory Committee, which reported to the QMC, the non-MCO attendees only included three members and zero providers. Additionally, while HSAG received Quality Improvement Committee (QIC) meeting minutes, which was described as a corporate or regional committee, HSAG would have expected the MCO to have an active IQAP committee at the local level overseeing its IQAP for the Nevada Medicaid program. HSAG requested examples of QMC meeting minutes; however, none were received.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	Required Actions: The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the MCO. This committee or other structure must: • Meet regularly with a specified frequency, no less than quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions. • Have a specified role, structure, and function. • Maintain records documenting the structure and committee's activities, findings, recommendations, and actions. • Have IQAP subcommittees that are accountable to the Governing Body and report to it (or its designee) on a scheduled basis on activities, findings, recommendations, and actions. Ensure the MCO providers actively participate in the IQAP committee as representatives of the composition of the MCO's providers.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Party: Lisa Werlech, Director of Quality Management Anthem Nevada has had an established Quality Management Committee (QMC) at the plan level since inception. In Appendix A (Medicaid Committee Structure) of the 2019 QM Program Description (attachment to be provided upon request), there is a description of the QMC and its committee charter. Meetings are held no less frequently than quarterly and the QMC reports to the Nevada Board of Directors. Subcommittees of the QMC are the Joint Consumer and Provider Advisory Committee and the Medical Advisory Committee (MAC). Both report their committee's findings and activities, as minutes, to the QMC. Anthem can provide an example of 2019 QMC minutes, including MAC minutes showing discussion, upon request. The Governing Body charter is also a part of the written committee description in Appendix A of the QM Program. There was an error in this Appendices template for 2019 only which has since been corrected. There has been a Nevada Board of Directors since the plan's inception. The 2020 QM Program Description (attachment to be provided upon request) reflects the Health Plan Board of Directors on the first page of Appendix A. Please see Anthem's corrective action plan response to DHCFP Contract §3.10.9.6 regarding reporting to the Governing Body.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[C-1]**	**Score**
	Although there are external MCO physicians on the MAC that receive important quality reports and analyses already, and offer feedback, Anthem is adding MCO physicians to the QMC as well. Two external providers that currently attend the MAC have been added to the QMC. One of these providers attended the October 2020 QMC meeting (minutes available upon request), and both are invited to the next QMC meeting scheduled for December. We are in the process of recruiting additional providers and are awaiting responses on commitments. Completion Date: The QMC structure outlined above is already in place. Regarding recruitment of providers for QMC participation, two external providers have been added to the QMC with additional recruitment ongoing.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(3)	4. Staff Recruitment and Retention *The CCP must contain a description of staff recruitment and retention. The MCO must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the MCO's members. Cultural competence is part of job descriptions.*	**Documents Submitted:** 2019 CLAS and Health Disparities Program Description **Description of Process:** Anthem recruits and employs qualified leadership, management, and staff to administer and support Plan services and programs. Bilingual associates are recruited to reflect the demographics of membership in specific job positions. Anthem is committed to attracting, retaining, developing, and advancing a world class workforce representative of the views, perspectives, experiences, and health care needs of a diverse population of consumers. Please see attached 2019 CLAS and Health Disparities Program Description with corresponding bookmarks labeled, "XII 4 – Staff Recruitment and Retention".	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The job description example (Community Relations Representative 1) listed as a qualification that a bilingual English/ Spanish speaking individual was strongly preferred. The job description included a statement at end that identified the MCO as a 2018 DiversityInc Magazine Top 50 Company for Diversity. No other reference to cultural competence was noted in the job description.		
	Required Actions: The MCO must ensure that cultural competence is part of its job descriptions.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Party: George Hoffmaster, Director Talent Acquisition Anthem will revise the description in job postings (for positions that support Nevada Medicaid) to state that Anthem promotes the delivery of services in a culturally competent manner and considers cultural competency when evaluating applicants for all Anthem positions. Completion Date: New job postings on or after December 7, 2020		

Standard XII: Cultural Competency Program			
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HSAG Response	In response to HSAG's follow-up to Anthem's remediation plan, Anthem clarified that it will revise job posting descriptions to ensure cultural competence is part of the description for all new job postings effective December 7, 2020. HSAG strongly recommends that Anthem ensure that it has a mechanism in place to demonstrate that all job postings associated with specific staff positions are maintained and include the requirements for this element. HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
42 CFR §438.10(h)(1)(vii)	12. Providers' Cultural and Linguistic Capabilities *The MCO must make members aware of the provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.*	**Documents Submitted:** Member Handbook (effective 8-2019 to present) Provider Director Screenshot – Languages Example.pdf **Description of Process:** The attached Member Handbook instructs members to visit the Member Website to access or download a provider directory. Please see attached Member Handbook (effective 8-2019 to present) with corresponding bookmark labeled, "XII 12 – Provider Directory" and PDF titled Provider Directory Screenshot – Languages Example.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Member Handbook directed members to the MCO's Member Website to access the provider directory in both English and Spanish. The English online provider directory identified what languages are spoken at the provider's office as well as whether the provider had received cultural competency training. While the Spanish online provider directory		

Standard XII: Cultural Competency Program			
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	identified what languages were spoken in provider offices, it did not identify if the provider had received cultural competency training as required by federal rule.		
	Required Actions: The MCO's Spanish online provider directory must identify if providers have received cultural competency training as required by federal rule.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Party: Joy Cleveland, RVP Provider Solutions The Spanish version of Anthem's online provider directory identifies when providers have received cultural competency training. Anthem can provide an excerpt upon request. Note that CMS has released Medicaid managed care regulatory changes, linked below, that directly impact this requirement. https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care 42 CFR 438.10(h)(1)(vii) is being revised to eliminate the phrase "and whether the provider has completed cultural competence training." As such, Anthem respectfully requests closure of this corrective action plan. Completion Date: N/A. Currently compliant but requesting closure of CAP.		
HSAG Response	The requirement for identifying whether the provider has completed cultural competence training has been removed from the updated federal regulations and effective December 2020. Please note that while cultural competence training is no longer a requirement for the provider directory, CMS regulations continue to require MCOs to collect cultural competence data to be included in the provider directory. HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.56(c)(1) *42 CFR §438.56(d)(2)(i-v)* *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (H)*	5. MCO Denies Request to Disenroll *If the MCO denies the request for disenrollment for lack of good cause the MCO must send a Notice of Decision in writing to the member upon the date of the decision.* *a) Appeal rights must be included with the Notice of Decision.* *b) The MCO is required to inform the member of their right to first appeal through the MCO and if the appeal is denied to request a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1).*	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67, 68) PP Member Request for Disenrollment-NV Member Disenrollment Form Disenrollment Denial Letter Disenrollment Acknowledgement Letter. **Description of Process:** Member requests for appeal of disenrollment denials must be received at the Health Plan within 30 days of the date of the disenrollment denial notice of action. 1. When a written appeal request is received at the health plan, an acknowledgement letter sent to member within 5 days. 2. Investigation of appeal is conducted through the appeal process. 3. A senior administrator who was not involved in the initial denial will review the case to determine if “good cause” guidelines are met. 4. The appeal decision is completed and Notice of Decision letter is sent to	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		member within 30 days of receipt of appeal request. o The notification of denial of appeal request includes information on member rights to a State Fair Hearing, how to obtain hearing and representation rules.	
	Findings: The MCO's Member Handbook and Member Request for Disenrollment policy indicated that disenrollment requests are reviewed within 14 days; however, these documents inaccurately stated that the member would receive a letter within 10 days after the decision was made instead of upon the date of decision, as required. A redacted disenrollment decision letter showed the letter was drafted on September 27 for a disenrollment request received on September 24. The letter did not include a date of decision; so, the time between the decision and the mailing of the letter could not be confirmed. Additionally, although the Notice of Decision template letter and redacted letter included appeal and State fair hearing rights, the letters included inaccurate appeal and State fair hearing time frames. After the virtual review, the MCO updated the appeal and State fair hearing time frames within its Notice of Decision letter and policy to 60 and 120 days, respectively.		
	Required Actions: If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a Notice of Decision in writing to the member upon the date of the decision. The MCO must also ensure that the member receives appeal and State fair hearing rights with accurate time frames.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Party: Lina Quintero, Director Grievance and Appeals (interim) Anthem's Member Request for Disenrollment - NV policy (available upon request) has been revised to remove the inaccurate language and now states that a "written notice of determination must be mailed to the member or the member's representative upon the date of decision." The revision to this policy were finalized on October 7, 2020. Revisions to the below Anthem member materials are in the process of internal review and will be submitted to DHCFP for approval once finalized: • Member Handbook (replacement of "within 10 calendar days of when we make our decision" with "upon the date of decision")		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	• Disenrollment Decision Letter (inclusion of the date the decision was made) • Disenrollment Appeal Rights Attachment (update to the timeframes within which an appeal and fair hearing must be requested to 60 days and 120 days respectively) Completion Date – Submission of revised materials to DHCFP is estimated for December 18, 2020. Implementation date will vary depending upon date of State approval.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (C)(1-7)*	8. Reasons an MCO May Not Request Disenrollment The MCO may not request disenrollment of a member for any of the following reasons: a) An adverse change in the member's health status; b) A pre-existing medical condition; c) The member's utilization of medical services; d) Diminished mental capacity; e) Uncooperative or disruptive behavior resulting from his or her special needs (except when continued enrollment of such a member seriously impairs the MCO's ability to furnish services to either this particular member or other members); f) A member's attempt to exercise his or her grievance or appeal rights; or	**Documents Submitted:** nvnv_caid_memberhandbook, (pp. 66, 67, 68) PP Member Request for Disenrollment-NV **Description of Process:** Anthem adheres to RFP 3260 §3.5.7.4(C) regarding "Disenrollment at the Request of the Vendor," as well as in accordance with 42 CFR 438.56. Anthem is prohibited from requesting any member's disenrollment for the reasons outlined in the above-referenced RFP. Consequently, the process to disenroll a member follows Anthem's Disenrollment Policy requiring the Quality Management Director to review all	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	g) Based on the member's national origin creed, color, sex, religion, or age.	disenrollment requests, including internal Anthem requests to disenroll a member. This review ensures compliance with both the RFP and federal law, while also ensuring consistency in Anthem's review and decision-making.	
	Findings: The MCO's Member Handbook included a section labeled *Other Information*, which had instructions for how the member could disenroll from Anthem. The handbook also included the reasons a member could be disenrolled by the MCO but did not contain the reasons that a member could not be disenrolled by the MCO. The Member Request for Disenrollment policy also had no mention of the reasons the MCO is not permitted to request disenrollment of a member. After the virtual review, the MCO provided its Involuntary Termination Initiated by Anthem NV desktop procedure, which met the intent of this requirement; however, the procedure document was not developed until August 14, 2020.		
	Required Actions: The MCO may not request disenrollment of a member for any of the reasons identified in federal and State regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Party: Chris Tyler, Staff VP Compliance Anthem will develop a new policy to govern MCO requests for disenrollment to include compliance with Contract and federal requirements regarding when MCOs may not request disenrollment. The Member Handbook will also be revised to indicate reasons for which Anthem cannot request disenrollment. Completion Date: Policy to be finalized by December 15, 2020. Member Handbook to be submitted for DHCFP review and approval by December 18, 2020. Implementation date of handbook changes will vary depending upon date of State approval.		
HSAG Response	HSAG has determined that the MCO's CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		