



**Division of Health Care Financing and Policy  
Nevada Medicaid Managed Care**

**State Fiscal Year 2021  
Compliance Review**  
*for*  
**Anthem Blue Cross and Blue Shield  
Healthcare Solutions**

*October 2021*



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## Background

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the state, an agent that is not a Medicaid managed care entity (MCE), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid MCE’s compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

To comply with the federal requirements, the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct compliance reviews of its contracted MCEs responsible for the delivery of comprehensive healthcare services, including physical health (PH), behavioral health (BH), and long-term services and supports (LTSS), as applicable, under the State’s Medicaid managed care program.

## Description of the External Quality Review of Compliance With Standards

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The state fiscal year (SFY) 2021 compliance review commenced a new three-year cycle of compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable State contract requirements. The compliance reviews in Nevada consist of 14 standards or program areas. DHCFP requested that HSAG conduct a review of the first seven standards in Year One (SFY 2021). The remaining seven standards will be reviewed in Year Two (SFY 2022). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews. Table 1-1 outlines the standards reviewed over the new three-year review cycle.

**Table 1-1—Three-Year Cycle of Compliance Reviews**

Compliance Monitoring Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Disenrollment: Requirements and Limitations	✓		Review of MCE implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		

Compliance Monitoring Standard	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

## Overview of Findings

### Review of Standards

From a review of documents, observations, and interviews with key **Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem)** staff members as well as file reviews conducted during the desk review and virtual interviews, the reviewers assigned **Anthem** a score for each element and an aggregate score for each standard. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2—Methodology. If a requirement was not applicable to **Anthem** during the period covered by the review, HSAG used a *Not Applicable (NA)* designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Table 1-2 presents a summary of **Anthem**'s performance results.

**Table 1-2—Summary of Standard Compliance Scores**

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				<i>M</i>	<i>NM</i>	<i>NA</i>	
I	Disenrollment: Requirements and Limitations	7	7	7	0	0	100%
II	Member Rights and Member Information	22	22	21	1	0	95%
III	Emergency and Poststabilization Services	10	10	10	0	0	100%
IV	Availability of Services	10	10	10	0	0	100%

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
V	Assurances of Adequate Capacity and Services	2	2	2	0	0	100%
VI	Coordination and Continuity of Care	17	17	16	1	0	94%
VII	Coverage and Authorization of Services	15	15	13	2	0	87%
<b>Total</b>		<b>83</b>	<b>83</b>	<b>79</b>	<b>4</b>	<b>0</b>	<b>95%</b>

*M = Met; NM = Not Met; NA = Not Applicable*

**Total Elements:** The total number of elements within 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), then dividing this total by the total number of applicable elements.

**Anthem** demonstrated compliance in 79 of 83 elements, with an overall compliance score of 95 percent, indicating that most program areas had the necessary policies, procedures, and initiatives in place to carry out the majority of the functions included as part of the review, while other areas demonstrated opportunities for improvement to operationalize the elements required by federal and State regulations. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

## Corrective Action Process

For any elements scored *Not Met*, **Anthem** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP and the criteria used to evaluate the sufficiency of the CAP are described in Section 3 of this report.

### Introduction

The following description of the way HSAG conducted—in accordance with 42 CFR §438.358—the external quality review (EQR) of compliance with standards for the Nevada Medicaid managed care program addresses HSAG’s:

- Objective of conducting the review of compliance with standards.
- Compliance review activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG followed standardized processes in conducting the review of the MCE’s performance.

### Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG’s review was to provide meaningful information to DHCFP and the MCE regarding compliance with the State and federal requirements. HSAG assembled a team to:

- Collaborate with DHCFP to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, virtual review<sup>2-1</sup> activity schedules, and virtual review agenda.
- Collect and review data and documents before and during the virtual review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective, and based on the results of collaborative planning with DHCFP, HSAG developed and used a data collection tool to assess and document the MCE’s compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHCFP contractual requirements. Beginning in SFY 2021, DHCFP requested that HSAG conduct compliance reviews over a three-year cycle with one-half of the standards being reviewed in Year One and the remaining half of the standards in Year Two, and a comprehensive review of each element scored as *Not Met* during Year One (SFY 2021) and Year Two (SFY 2022) during Year Three (SFY 2023). The division of standards over the three years can be found in Table 1-1. The review tool developed for this year’s review (SFY 2021) included requirements that addressed the following performance areas:

- Standard I—Disenrollment: Requirements and Limitations

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<sup>2-1</sup> Due to the current pandemic, the on-site review component of the compliance activity was held virtually via Webex.

- Standard II—Member Rights and Member Information
- Standard III—Emergency and Poststabilization Services
- Standard IV—Availability of Services
- Standard V—Assurances of Adequate Capacity and Services
- Standard VI—Coordination and Continuity of Care
- Standard VII—Coverage and Authorization of Services

DHCFP and the MCE will use the information and findings that resulted from HSAG’s review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

## Compliance Review Activities and Technical Methods of 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 laws and on the requirements set forth in the contract between DHCFP and the MCE as they related to the scope of the review. HSAG also followed the guidelines set forth in the Centers for Medicare & Medicaid Services’ (CMS’) *EQR Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019<sup>2-2</sup> for the following activities:

### Pre-Review Activities

Pre-review activities included:

- Scheduling the virtual reviews.
- Developing the compliance review tools.
- Preparing and forwarding to the MCE a pre-review information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-review preparation session with the MCE.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP, and of documents the MCE submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the MCE’s

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<sup>2-2</sup> 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.medicare.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Jul 12, 2021.

operations, identify areas needing clarification, and begin compiling information before the virtual review.

- Generating a list of 10 sample records for service authorization denials and care management from the universe files submitted to HSAG from the MCE.
- Developing the agenda for the one-day virtual review.
- Providing the detailed agenda to the MCE to facilitate preparation for HSAG’s virtual review.

## **Virtual Review Activities**

Virtual review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG’s one-day review activities.
- A review of the documents HSAG requested that the MCE have available during the interview sessions.
- A review of service authorization denial and care management records HSAG requested from the MCE.
- A review of the data systems that the MCE used in its operation such as utilization management, care coordination, and enrollment and disenrollment.
- Interviews conducted with the MCE’s key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

HSAG documented its findings in the data collection tool (compliance review tool) shown in Appendix A—Review of the Standards, which serves as a comprehensive record of HSAG’s findings, performance scores assigned to each requirement, and the actions required to bring the MCE’s performance into compliance for those requirements that HSAG assessed as less than fully compliant.

## **Description of Data Obtained**

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- MCE-maintained records for service authorization denials.
- MCE’s online member handbook and provider directory.



HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE’s key staff members.

Table 2-1 lists the major data sources HSAG used to determine the MCE’s performance in complying with requirements and the time period to which the data applied.

**Table 2-1—Description of MCE Data Sources**

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during the virtual review	November 1, 2020–May 31, 2021
Information obtained through interviews	September 16, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding denials of payment and concurrent reviews) between November 1, 2020–May 31, 2021
Information obtained from a review of a sample of care management records for file reviews	Listing of members newly enrolled into care management on or after September 1, 2020

## Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE’s performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG’s review. This scoring methodology is consistent with CMS’ *EQR Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. 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, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

**Not Met** indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have 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* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements *Not Applicable* to the MCE were scored *NA* and were not included in the denominator of the total score.

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

For the member handbook, provider directory, member rights, appointment standards, and time/distance standards checklists reviewed, HSAG assessed each applicable element within the checklist as either (1) *Yes*, the element was contained within the associated document(s), or (2) *No*, the element was not contained within the document(s). Elements *Not Applicable* to the MCE were assessed as *NA*. The findings from the checklists were used to determine overall compliance with the applicable standard and element in the compliance review tool (i.e., member handbook content requirements within Standard I–Member Rights and Member Information).

HSAG conducted file reviews of the MCE’s records for service authorization denials and care management to verify that the MCE had put into practice what the MCE had documented in its policy, in addition to adhering to timely review of authorization and care management requirements. HSAG selected 10 records of service authorization denials and 10 records for care management from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE’s files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

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

- Documented findings describing the MCE’s progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE’s performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- 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 a score of *Not Met*.

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

### 3. Corrective Action Plan Process

Appendix C contains the CAP template that HSAG developed for **Anthem** to use in preparing its CAP to be submitted to DHCFP. The template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **Anthem** must use this template to submit its CAP to bring any elements scored *Not Met* into compliance with the applicable standard(s). **Anthem's** CAP must be submitted to DHCFP and HSAG no later than 30 calendar days of receipt of HSAG's final *State Fiscal Year 2021 Compliance Review* report.

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

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned activities/interventions are anticipated to bring the organization 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 organization until approved by DHCFP. DHCFP maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **Anthem** in its submitted CAP.



## Appendix A. Review of the Standards

Following this page is the completed compliance review tool that HSAG used to evaluate **Anthem**'s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring **Anthem**'s performance into full compliance.



**Appendix A. Review of the Standards  
Nevada Division of Health Care Finance and Policy  
State Fiscal Year 2021 MCE Compliance Review  
for Anthem Blue Cross and Blue Shield Healthcare Solutions**

Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Disenrollment Requested by the Managed Care Organization (MCO)</b>		
<p>1. The MCO may not request disenrollment:</p> <ul style="list-style-type: none"> <li>• Because of an adverse change in the member’s health status,</li> <li>• <i>The member has a pre-existing medical condition,</i></li> <li>• Because of the member’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO seriously impairs the entity’s ability to furnish services to either this particular member or other members),</li> <li>• <i>A member’s attempt to exercise his/her grievance or appeals rights, or</i></li> <li>• <i>Based on the member’s national origin, creed, color, sex, religion, and age.</i></li> </ul> <p style="text-align: right;">42 CFR §438.56(b)(2) Contract 3.5.2, 3.5.7.4 (C)(1-7)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• Involuntary Disenrollment – NV: pages 1 and 2</li> <li>• NV Member Handbook: pages 64 and 65 (footer page #s)</li> <li>• NV Member Handbook Insert</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem has attached the copy of the member handbook that was effective for the review period. Note that Anthem produced a handbook insert (also enclosed) in December 2020 to address a previous finding regarding the incorporation of this language. The actual handbook was subsequently revised in June 2021 to incorporate this requirement. See page 68 of the handbook on the Anthem member web site: <a href="https://mss.anthem.com/nevada-medicaid/nvncaid_memberhandbook_eng.pdf">https://mss.anthem.com/nevada-medicaid/nvncaid_memberhandbook_eng.pdf</a> (section “Reasons you cannot be disenrolled from Anthem”).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Member Disenrollment Request by the MCO</b>		
<p>2. The MCO assures DHCFP that it does not request disenrollment for reasons other than those permitted under the contract.</p> <p>a. <i>The MCO may request disenrollment of a member if the continued enrollment of the member seriously impairs the MCO’s ability to furnish services to either the particular member or other members.</i></p> <p>b. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.56(b)(3) Contract 3.5.7.4(A)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Example of an MCO disenrollment request (if the MCO has not requested any member disenrollment, state so in the MCO Description of Process)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b> Involuntary Disenrollment – NV; pages 1 and 2</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b> Anthem has not requested any member disenrollment.		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None		
<b>Disenrollment Requested by the Member</b>		
<p>3. A member may request disenrollment as follows:</p> <p>a. For cause, at any time.</p> <p>i. <i>If the MCO determines that there is sufficient cause to disenroll, the MCO must notify the DHCFP by using the state-required form. The MCO must make a determination as expeditiously as the member’s health</i></p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b> Member Request for Disenrollment – NV: All</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p><i>requires and within a timeline that may not exceed fourteen (14) calendar days following receipt of the request for disenrollment.</i></p> <p>b. Without cause, at the following times:</p> <ul style="list-style-type: none"> <li>i. During the 90 days following the date of the member’s initial enrollment into the MCO, or during the 90 days following the date DHCFP sends the member notice of that enrollment, whichever is later.</li> <li>ii. At least once every 12 months thereafter.</li> <li>iii. Upon automatic reenrollment under 42 CFR §438.56(g), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.</li> <li>iv. When DHCFP imposes the intermediate sanction specified in 42 CFR §438.702(a)(4).</li> </ul> <p style="text-align: right;">42 CFR §438.56(c)(1-2) 42 CFR §438.56(g) 42 CFR §438.702(a)(4) Contract 3.5.7.3 (A-D), (F)(1)(d), (G)</p>	<p>NV Member Handbook; Pages 64 and 65 (footer page #s) NV Member Handbook Insert</p>	
<p><b>MCO Description of Process:</b> Anthem has attached the copy of the member handbook that was effective for the review period. Note that Anthem produced a handbook insert (also enclosed) in December 2020 to address a previous recommendation to remove the language in the handbook regarding sending the member a letter within 10 days of the determination. The actual handbook was subsequently revised in June 2021 to incorporate this requirement. See top of page 68 of the handbook on the Anthem member web site: <a href="https://mss.anthem.com/nevada-medicaid/nvncaid_memberhandbook_eng.pdf">https://mss.anthem.com/nevada-medicaid/nvncaid_memberhandbook_eng.pdf</a>.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		





**Appendix A. Review of the Standards**  
**Nevada Division of Health Care Finance and Policy**  
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Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Procedures for Disenrollment: Request for Disenrollment</b>		
<p>4. The member (or his or her representative) must submit an oral or written request, as required by DHCFP—to the MCO.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.56(d)(1)(ii) Contract 3.5.7.3(F)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Example of a member disenrollment request</li> </ul> <p><b>Evidence as Submitted by the MCO:</b>            Member Request for Disenrollment – NV: page 3, paragraph 2            NV Member Handbook: page 64 (footer page #), bottom of page            Disenrollment Denial Email to DHCFP            Disenrollment Denial Example            Disenrollment Denial Letter –Example            2021 Disenrollment Report: report notes mail and verbal requests received</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<b>Procedures for Disenrollment: Cause for Disenrollment</b>		
<p>5. The member may request to disenroll from the MCO for good cause at any time. Good cause for disenrollment includes:</p> <p style="margin-left: 20px;">a. The member moves out of the MCO’s service area.</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>b. The plan does not, because of moral or religious objections, cover the service the member seeks.</p> <p>c. The member needs related services (for example, a Cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member’s primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.</p> <p>d. For members that use Managed Long Term Services and Supports (MLTSS), the member would have to change their residential, institutional, or employment supports provider based on that provider's change in status with the MCO and, as a result, would experience a disruption in their residence or employment.</p> <p>e. Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member’s care needs.</p> <p style="text-align: right;">42 CFR §438.56(d)(2)(i-v) Contract 3.5.7.3(F)(1)</p>	<p><b>Evidence as Submitted by the MCO:</b></p> <p>Member Request for Disenrollment – NV: page 1, Good Cause definition</p> <p>NV Member Handbook: page 65 (footer page #), second bullet</p>	
<p><b>MCO Description of Process:</b> LTSS services carved out of Anthem contract with DHCFP.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element. Although sub-element d was not demonstrated through documentation, HSAG has determined this sub-element to be not applicable as this specific requirement would most likely relate to LTSS waiver members under fee-for-service.</p>		
<p><b>Required Actions:</b> None.</p>		



**Appendix A. Review of the Standards**  
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Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Use of the MCO’s Grievance Procedures</b>		
<p>6. <i>The DHCFP requires that the member seek redress through the MCO’s grievance system before making a determination on the member’s request.</i></p> <p>a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the time frame specified in 42 CFR §438.56(e)(1).</p> <p>b. <i>If the MCO cannot make a determination, the MCO may refer the request to DHCFP.</i></p> <p align="right">42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) Contract 3.5.7.3 (I)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• One case example of a member request for disenrollment grievance record, including the resolution letter</li> <li>• Most recent member disenrollment report</li> </ul> <p><b>Evidence as Submitted by the MCO:</b> Member Request for Disenrollment – NV: page 3, paragraph 7 2021 Disenrollment Report 6_Disenrollment Case File: resolution letter on page 39</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Note: Related to the 2/19/21 disenrollment request on the 2021 Disenrollment Report, decision/date/explanation is blank as the disenrollment request form mailed to the member’s mother was not returned to Anthem with a reason for disenrollment.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>7. <i>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 and include appeal rights. 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 and how to obtain such a hearing.</i></p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• One case example of a member request for disenrollment denied due to lack of good cause, including the Notice of Decision letter sent to the member.</li> <li>• Disenrollment request monitoring report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Disenrollment: Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>a. <i>If DHCFP receives a request directly from the member, the member will be directed to begin the process by requesting disenrollment through the vendor.</i></p> <p style="text-align: right;">42 CFR §438.56(d)(5)(i) Contract 3.5.7.3 (H),(K)</p>	<p><b>Evidence as Submitted by the MCO:</b>            Member Request for Disenrollment – NV: page 4, paragraph 12 and “Member Appeal of Disenrollment Denial”            Disenrollment Denial Email to DHCFP            Disenrollment Denial Example            Disenrollment Denial Letter –Example            2021 Disenrollment Report</p>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		

Standard I—Disenrollment: Requirements and Limitations						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
<b>Total Applicable</b>	=	7	<b>Total Score</b>		=	7
<b>Total Score ÷ Total Applicable</b>					=	<b>100%</b>



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Standard II— Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<b>Member Rights: General Rule</b>		
1. The MCO has written policies regarding the member rights specified in 42 CFR §438.100.  <div style="text-align: right; font-size: small;">42 CFR §438.100(a)(1) Contract 3.10.16.1</div>	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> </ul> <hr/> <b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>1.Member Rights and Responsibilities_NV: All</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
2. The MCO complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights.  <div style="text-align: right; font-size: small;">42 CFR §438.100(a)(2)</div>	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual, provider contract, and provider training materials</li> <li>Employee training materials</li> <li>Auditing/oversight mechanisms</li> </ul> <hr/> <b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>2.Member Rights and Responsibilities_NV; page 1, 2, 3 (paragraphs 1 and 4)</li> <li>NV Provider Manual_Master: pages 41-42 (footer page #s) Section 5.11 Member Rights and Responsibilities</li> <li>2.Provider Sample Contract: page 3, Section 2.2</li> <li>2_2020 Medicaid Cultural Competency Refresher</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>2.HIPAA Mbr Rights Training Topics</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem’s 2020 Medicaid Cultural Competency Refresher training is given annually and is required for all associates supporting our Medicaid members. Customer Service also trains on this topic during its formal HIPAA training. Regarding additional oversight mechanisms, if a member complaint is received related to issues with providers not respecting member rights, a grievance is initiated and reviewed by a Grievance Analyst. The analyst will reach out to Provider Relations requesting review of the complaint with the provider to further educate/refresh the provider on member rights and their contractual obligations.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<b>Specific Rights: Basic Requirement</b>		
<p>3. The MCO ensures that each managed care member is guaranteed the rights as specified in 42 CFR §438.100(b)(2) and (3)—Refer to the Member Rights Checklist.</p> <p style="text-align: right; font-size: small;">42 CFR §438.100(b)(1-3) Contract 3.6.1.1(B)(6), 3.6.1.2(A)(1), 3.10.16.1</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• HSAG will use the results of the Member Rights Checklist.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 3. Member Rights and Responsibilities_NV: All</li> <li>• NV Member Handbook: Page 69 (footer page #, Bookmark: Standard I: Member Rights)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b></p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<b>Language Requirements: Basic Rule</b>		
<p>4. The MCO uses:</p> <p>a. Definitions for managed care terminology, including appeal, copayment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, nonparticipating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.</p> <p>b. Model member handbook and member notices.</p> <p style="text-align: right;">42 CFR §438.10(c)(4)(i-ii)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Model member handbook and notice templates, as applicable</li> <li>Member materials, such as the member handbook</li> <li>Member notice templates, such as ABD, grievance, and appeal letter templates</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>NV Member Handbook: Definitions Bookmarks (subcategories)</li> <li>4.Medical Necessity Appeals_NV: Definitions, pages 1-2</li> <li>4.Member Grievance Resolution_NV; Definitions, pages 1-2</li> <li>4.Member Appeal Upheld Letter</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p> <p><b>Recommendations:</b> While the MCO demonstrated that it defines and used most managed care terms, HSAG strongly recommends that the MCO thoroughly review all applicable documents to ensure all managed care terms are clearly defined. HSAG further recommends that the MCO consult with DHCFP to determine whether a model member handbook and notices can be developed to comply with federal rule.</p>		
<b>Required Actions:</b> None.		



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<p>5. Member information required in 42 CFR §438.10 may not be provided electronically by the MCO unless all of the following are met:</p> <ul style="list-style-type: none"> <li>a. The format is readily accessible;</li> <li>b. The information is placed in a location on the MCO’s website that is prominent and readily accessible;</li> <li>c. The information is provided in an electronic form which can be electronically retained and printed;</li> <li>d. The information is consistent with the content and language requirements of 42 CFR §438.10; and</li> <li>e. The member is informed that the information is available in paper form without charge upon request and the MCO provides it upon request within five (5) business days.</li> </ul> <p style="text-align: right;">42 CFR §438.10(c)(6)(i-v)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Example of member information that is only provided in an electronic format; and subsequent communication to inform the member of the availability of electronic information</li> <li>• Reporting or tracking mechanisms for providing member materials in paper form upon request</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 5. Developing and Revising Member Handbooks: page 7</li> <li>• 5.Member Materials _Appropriateness: pages 1-4 (core procedure), 13-14 (Nevada exception)</li> <li>• 5.Tracking_Report_NV_2021_DRT_Requests Report</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> The majority of information required by 42 CFR §438.10 is communicated to members in our member handbook which is included in our mailed, paper welcome packet. The member handbook is posted prominently on our web site (<a href="https://mss.anthem.com/nevada-medicaid/benefits/medicaid-benefits.html">https://mss.anthem.com/nevada-medicaid/benefits/medicaid-benefits.html</a>) using 508-compliant PDFs (reference Developing and Revising Member Handbooks policy as well as response to Requirement 9 within this tool). Note that this page also instructs members to call Member Services if they need a handbook mailed to them.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		





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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<b>Language and Format</b>		
<p>6. The MCO makes its written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area.</p> <p>a. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential member or member at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and Telecommunications Device for the Deaf/TeleTYpewriter (TTY/TDY) telephone number of the MCO's member/customer service unit.</p> <p>b. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost.</p> <p style="text-align: right;">42 CFR §438.10(d)(3) Contract 3.6.1</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Spanish member handbook (provide handbook and link to website)</li> <li>Spanish provider directory (provide excerpts of directory and link to website)</li> <li>Taglines included with member information</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>6.Member Materials_Appropriateness: pages 1-3</li> <li>6. Req For Translations Alternative Formats: pages 1-3</li> <li>NV Member Handbook Spn</li> <li>Spanish Member Handbook Link - <a href="https://mss.anthem.com/nevada-medicaid/nvnev_caid_memberhandbook_spa.pdf">https://mss.anthem.com/nevada-medicaid/nvnev_caid_memberhandbook_spa.pdf</a></li> <li>NV Medicaid Provider Directory North: Note this is English/Spanish combined. “Your rights” bookmark includes member rights regarding alternative formats/languages as well as translated taglines.</li> <li>NV Medicaid Provider Directory South: Note this is English/Spanish combined. “Your rights” bookmark includes member rights regarding alternative formats/languages as well as translated taglines.</li> <li>Spanish Provider Directory Links (note these are English/Spanish combined): <a href="https://mss.anthem.com/nevada-">https://mss.anthem.com/nevada-</a></li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<a href="#">medicaid/nvnm_caid_pd_north.pdf</a> and <a href="https://mss.anthem.com/nevada-medicaid/nvnm_caid_pd_south.pdf">https://mss.anthem.com/nevada-medicaid/nvnm_caid_pd_south.pdf</a> <ul style="list-style-type: none"> <li>6.NV Taglines_BabelSheet</li> <li>6.NV Taglines_Non-Discrim Policy</li> </ul>	
<b>MCO Description of Process:</b>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p> <p><b>Recommendations:</b> HSAG recommends that the MCO define “conspicuously visible” font size to be greater than a 12-point font to ensure the taglines are clearly visible and stand out from the other text in written materials critical to a member obtaining services (e.g., the provider directory, the member handbook, grievance and appeal notices, and denial and termination notices).</p>		
<b>Required Actions:</b> None.		
<p>7. The MCO provides information to members who are limited English proficient through the provision of language services at no cost to the individual.</p> <p>a. <i>Written information must also be available in the prevalent non-English languages, as determined by DHCFP, in its particular geographic service area.</i></p> <p>b. The MCO shall also identify additional languages that are prevalent among the MCO’s membership.</p> <p>i. <i>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.</i></p> <p>ii. <i>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</i></p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Linguistic analysis of the member population</li> <li>Screen shot of the health information system (HIS) where the primary language of the member is stored</li> <li>Workflow for generating member materials/information in a member’s primary language (English and Spanish) that is stored in the HIS</li> <li>Two examples of member notices, such as an ABD notice, grievance resolution letter, and appeal resolution letter, etc., sent in Spanish</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>7.Member Materials_Appropriateness: pages 13-14, 3</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<p><i>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.</i></p> <p>iii. <i>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 who speak that language and have LEP.</i></p> <p>c. Written information shall be provided in any such prevalent languages identified by the MCO.</p> <p style="text-align: right;">42 CFR §438.10(d)(4)            42 CFR. §438.340(b)(6)            Contract 3.4.2.15(C)(3)(a-c), 3.6.1</p>	<ul style="list-style-type: none"> <li>7.Requesting Translation Policy: pages 2-3, 11, 3-4 (includes workflow)</li> <li>7.Standard II_Medical Necessity Appeals_NV: page 3</li> <li>7_NV 2020 CLAS Eval 3.16.21 Linguistic Analysis: pages 13-18</li> <li>7.NV Mbr Lang Screen Print</li> <li>7.Sample Spanish Grievance Resolution Letter</li> <li>7.Sample Spanish Appeal Resolution Letter.pdf</li> </ul>	
<p><b>MCO Description of Process:</b> Our NextGen system consumes the member's primary language from the member's record housed in our Facets system so the NextGen user can verify the member's language in NextGen. Other language letter templates are displayed in the drop-down along with English templates. If there is no template for the language needed (not all markets have templates configured in languages other than English) then an English letter is sent which includes the Babel sheet (all letters contain Babel Sheet) with instructions for the member to request translation services. Member materials are currently requested through our document request tool for translation.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<p>8. The MCO notifies its members:</p> <p style="margin-left: 20px;">a. That oral interpretation is available for any language and written translation is available in prevalent languages;</p> <p style="margin-left: 20px;">b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and</p> <p style="margin-left: 20px;">c. How to access the services in §438.10(d)(5)(i) and (ii).</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(d)(5)(i-iii) Contract 3.6.1</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>8.Member Materials_Appropriateness: page 3</li> <li>NV Member Handbook: PDF page numbers 8, 11, 83</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
<p>9. The MCO provides all written materials for potential members and members consistent with the following:</p> <p style="margin-left: 20px;">a. Use easily understood language and format.</p> <p style="margin-left: 20px;">b. Use a font size no smaller than 12 point.</p> <p style="margin-left: 20px;">c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or LEP, <i>in accordance with the requirements of the Americans with Disabilities Act of 1990.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(d)(6)(i-iii) Contract 3.6.1</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook and member newsletter</li> <li>Examples of member notices, such as an ABD notice, grievance resolution letter, appeal resolution letter, etc.</li> <li>Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services</li> <li>Workflow and verification procedures for ensuring member materials are 508 compliant</li> <li>Taglines included with member information</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 9. Member Materials_Appropriateness: pages 2-3</li> <li>• 9. Developing and Revising Member Handbooks: page 7</li> <li>• 9. Medical Necessity Appeals_NV; Page 3</li> <li>• 9. Member Grievance Resolution_NV: Pages 1, 3</li> <li>• NV Member Handbook: PDF page numbers 8, 11, 83</li> <li>• 9. Sample Appeal Resolution Letter</li> <li>• 9. Sample Grievance Resolution Letter</li> <li>• Tracking_Report_NV_2Q21_Translation Report</li> <li>• Tracking_Report_NV_2Q21_DRT_Requests_Report</li> <li>• 9_NV 2020 CLAS Eval 3.16.21: pages 23-25</li> <li>• 9. Web Site Accessibility Screen Shot</li> <li>• 9. Member Communications Job Process: page 10</li> <li>• 9. 508 Compliance Submission Process</li> <li>• 9. Writing for the Web: pages 1-2</li> </ul>	
<p><b>MCO Description of Process:</b> Taglines can be found included with the member letter samples, appeals resolution and grievance resolution letters.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<b>Information for All Members With MCO—General Requirements</b>		
<p>10. The MCO must make a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.</p> <p>a. Notice to the member must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.</p> <p style="text-align: right;">42 CFR §438.10(f)(1) Contract 3.6.1.1(D), 3.7.5.11(A)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Example of a written notice to members of provider termination (include the effective date of the termination or receipt or issuance of the termination notice for this example)</li> <li>Tracking or reporting mechanisms (mailing date and effective date of the termination or receipt or issuance of the termination notice must be notated)</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>10.PCP Termination and Member Notification: page 1, 7</li> <li>10. Term Letter Example</li> <li>10.NV_Term Ltr Tracking Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
<p>11. The MCO must make available, upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i).</p> <p style="text-align: right;">42 CFR §438.3(i) 42 CFR §438.10(f)(3) Contract 3.7.6.6</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Summary of physician incentive plans</li> <li>Example of physician incentive plans provided to a member upon request (if an example is not available, please state so under the MCO Description of Process)</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>11.NCC Requests to Mail Documents: page 2</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>11.Risk and Shared Savings Arrangement Management Policy: pages 1-3 (includes an overview of arrangement types)</li> <li>NV Member Handbook: PDF page number 75</li> <li>11.PQIP Program Description</li> <li>11.SDOHPIP Program Description</li> <li>11.OBQIP Program Description</li> <li>11.SUDFIP Program Description</li> </ul>	
<b>MCO Description of Process:</b> Anthem does not have an example of a physician incentive plan that was actually provided to a member as a request was not received within the review period.		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
Advance Directives		
12. Pursuant to Section 1902(w)(1) of the Social Security Act, the Patient Self-Determination Act, including advance directives, the MCO must have written policies and procedures with respect to all emancipated adult members receiving medical care through the MCO.  <div style="text-align: right; font-size: small;">42 CFR §438.3(j)(1) Contract 3.6.1.2</div>	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> </ul> <b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>12.13_Advance Directive: All</li> <li>12.13 Member Safety: pages 3-4</li> <li>12.13 CM Assessment Advance Directives: page 3</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
13. The MCO is required to provide written information to each member at the time of enrollment concerning: <ol style="list-style-type: none"> <li>The member’s rights, under State law, to make decisions concerning medical care, including the right to accept or refuse medical treatment and the right to formulate advance directives;</li> <li>The MCO’s policies with regard to a member’s right to execute an advance directive, including a requirement that the network provider present a statement of any limitations in the event the provider cannot implement an advance directive on the basis of conscience.</li> <li><i>At a minimum, the MCO’s statement of limitation, if any, must:</i> <ol style="list-style-type: none"> <li><i>Clarify any differences between institution-wide conscience objections and those that may be raised by individual network providers;</i></li> <li><i>Identify the State legal authority pursuant to Nevada Revised Statute (NRS) 449.628 permitting such objections; and</i></li> <li><i>Describe the range of medical conditions or procedures affected by the conscience objection.</i></li> </ol> </li> </ol> <p align="right">42 CFR §438.3(j)(3) Contract 3.6.1.2 (A)(1-2)</p>	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Written member informational materials</li> <li>Tracking reports</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>12.13_Advance Directive: pages 1-2</li> <li>12.13 Member Safety: pages 3-4</li> <li>12.13 CM Assessment Advance Directives: page 3</li> <li>NV Member Handbook: PDF page numbers 63-64</li> <li>13. Sample Adult HR Assessment Advance Directives</li> <li>13. Sample OB HR Assessment Advance Directives</li> </ul>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		





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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<b>Information for All Members With MCO—Member Handbook</b>		
<p>14. The MCO must provide each member a member handbook, <i>within five (5) business days</i> after receiving notice of the member’s enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR §147.200(a).</p> <p>a. <i>The MCO must notify all members of their right to request and obtain this information at least once per year or upon request.</i></p> <p style="text-align: right;">45 CFR §147.200(a) 42 CFR §438.10(g)(1) Contract 3.6.1.1(B)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Tracking or reporting mechanisms (include the date the MCO received notice of the member’s enrollment and the mailing date of the member handbook/member enrollment materials)</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 14.New Member Materials Distribution: pages 1, 2, 4</li> <li>• 14.Developing and Revising Member handbook: pages 1, 3, 11</li> <li>• 14. Member Newsletter Interactions: page 4</li> <li>• New Mbr Packet Tracking Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Note also that the member web site (<a href="https://mss.anthem.com/nevada-medicaid/benefits/medicaid-benefits.html">https://mss.anthem.com/nevada-medicaid/benefits/medicaid-benefits.html</a>) under “Your member resources” instructs members to call Member Services if they need a handbook mailed to them.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>15. The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program—Refer to the Member Handbook Checklist.</p> <p style="text-align: right;">42 CFR §438.10(g)(2) Contract 3.6.1.1</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Member handbook (provide handbook and link to website)</li> <li>• HSAG will also use the results of the Member Handbook Checklist.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• NV Member Handbook: All</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Web Site Links - <a href="https://mss.anthem.com/nevada-medicaid/nvnv_caaid_memberhandbook_eng.pdf">https://mss.anthem.com/nevada-medicaid/nvnv_caaid_memberhandbook_eng.pdf</a> and <a href="https://mss.anthem.com/nevada-medicaid/nvnv_caaid_memberhandbook_spa.pdf">https://mss.anthem.com/nevada-medicaid/nvnv_caaid_memberhandbook_spa.pdf</a></li> </ul>	
<b>MCO Description of Process:</b>		
<p><b>HSAG Findings:</b> The MCO demonstrated compliance with the elements of the member handbook checklist with the exception of one sub-element. The member handbook effective during the review period contained the incorrect time frame of 90 calendar days from receipt of the adverse benefit determination for a member to file an appeal, instead of the required 60 calendar days. This issue was also identified during the last compliance review (the handbook included incorrect time frames for filing of member appeals and State fair hearing requests). The MCO staff members provided follow-up documentation after the interview session that indicated the member handbook was updated to include the 60-calendar day appeal time frame in June 2021; however, this was outside of the review period for this compliance review.</p> <p><b>Recommendations:</b> HSAG recommends that the MCO consider updating terminology from “Notice of Action” to “Adverse Benefit Determination” to fully align with federal rule terminology.</p>		
<b>Required Actions:</b> The MCO must ensure that the member handbook contains the correct time frame for member appeals.		
<p>16. Information required by 42 CFR §438.10(g) (member handbook) is considered to be provided by the MCO if the MCO:</p> <ol style="list-style-type: none"> <li>Mails a printed copy of the information to the member’s mailing address;</li> <li>Provides the information by email after obtaining the member’s agreement to receive the information by email;</li> <li>Posts the information on the website of the MCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or</li> </ol>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Reporting or tracking mechanisms for providing the member handbook in paper form via mail</li> <li>Member enrollment materials</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>16.New Member Materials Distribution: pages 1, 2, 4</li> <li>16.Member Materials Appropriateness: page 3</li> <li>16. Developing and Revising Member Handbooks</li> <li>New Mbr Packet Tracking Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<p>d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information.</p> <p style="text-align: right;">42 CFR §438.10(g)(3) Contract 3.6.1.1</p>	<ul style="list-style-type: none"> <li>Tracking_Report_NV_2Q21_Translation Report</li> <li>Tracking_Report_NV_2Q21_DRT_Requests_Report</li> <li>NV Member Handbook: PDF page 10 (About this member handbook), page 9 (5th bullet under “Go online”)</li> <li>Relevant Anthem web site links (language assistance, availability of aids): <a href="https://mss.anthem.com/nevada-medicaid/nvnmv_caid_babelsheet.pdf">https://mss.anthem.com/nevada-medicaid/nvnmv_caid_babelsheet.pdf</a>, <a href="https://mss.anthem.com/nevada-medicaid/nvnmv_caid_non-discrimpolicy_eng.pdf">https://mss.anthem.com/nevada-medicaid/nvnmv_caid_non-discrimpolicy_eng.pdf</a>, <a href="https://mss.anthem.com/nevada-medicaid/nvnmv_caid_non-discrimpolicy_spa.pdf">https://mss.anthem.com/nevada-medicaid/nvnmv_caid_non-discrimpolicy_spa.pdf</a></li> </ul>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
<p>17. The MCO must give each member notice of any change that DHCFP defines as significant in the information specified in 42 CFR §438.10(g) (member handbook), at least 30 days before the intended effective date of the change, <i>when there are material changes that will affect access to services and information about the Managed Care Program.</i></p> <p style="text-align: right;">42 CFR §438.10(g)(4) Contract 3.6.1.1(C)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Example of a member notice due to a significant change in the information in the member handbook, including the date of notice and date of change (if no significant change, please state so under the MCO Description of Process)</li> <li>Tracking or reporting mechanisms for providing timely notice of a significant change</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>17.Developing and Revising Member Handbooks: pages 1, 3, 7-8, 11</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>17. Member Newsletter Interactions: page 4</li> <li>NV Member Handbook: PDF page 11 (1st paragraph)</li> </ul>	
<p><b>MCO Description of Process:</b> A benefits change letter is sent to members when a significant change occurs, however there was no significant change identified during the review period, thus an example and tracking/reporting mechanism has not been provided.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
Information for All Members of MCO—Provider Directory		
<p>18. The MCO must make available in paper form upon request and electronic form, information about its network providers—Refer to the Provider Directory Checklist.</p> <p style="text-align: right;">42 CFR §438.10(h) Contract 3.7.7, 3.14.7.2</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Provider directory (provide excerpts of the directory and link to the website)</li> <li>HSAG will also use the results of the Provider Directory Checklist.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>NV Medicaid Provider Directory North</li> <li>NV Medicaid Provider Directory South</li> <li>NV Member Handbook: PDF page 13 (Where to get a list of Anthem network providers)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem’s web site hosts the provider directory at <a href="https://mss.anthem.com/nevada-medicaid/care/find-a-doctor.html">https://mss.anthem.com/nevada-medicaid/care/find-a-doctor.html</a>. The right side of the page include links to the North and South Provider Directories (English/Spanish combined). Note that the print Provider Directory is also included in our new member welcome packets.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Recommendations:</b> While the MCO’s online printable provider directory contained all the requirements for this element, including the specific accommodations for persons with physical disabilities that are available at provider offices, the online provider search tool did not. MCO staff members</p>		



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Requirement	Supporting Documentation	Score
<p>explained during the interview session that the MCO had recently changed the platform for its online search tool and that plans were underway to align the online printable provider directory with the online provider search tool. HSAG strongly recommends that the MCO prioritize aligning its online provider search tool with the information in the online, printable version of the provider directory. Implementation of these recommendations will be further assessed during future compliance reviews.</p>		
<b>Required Actions:</b> None.		
<p>19. Information included in—</p> <p>a. A paper provider directory must be updated at least—</p> <p style="margin-left: 20px;">i. Monthly, if the MCO does not have a mobile-enabled, electronic directory; or</p> <p style="margin-left: 20px;">ii. Quarterly, if the MCO has a mobile-enabled, electronic provider directory.</p> <p>b. An electronic provider directory must be updated no later than 30 calendar days after the MCO receives updated provider information.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.10(h)(3) Contract 3.14.7.4, 3.16.5</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Verification of a mobile-enabled electronic provider directory</li> <li>Workflow to update the paper and electronic provider directories</li> <li>Evidence how updates to the paper and electronic provider directories are date stamped</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>19.P_P Provider Directories: pages 1-3, 16-17. Workflow begins on page 38.</li> <li>NV Medicaid Provider Directory North</li> <li>NV Medicaid Provider Directory South</li> <li>Anthem mobile-enabled Find A Doctor Tool - <a href="https://mss.anthem.com/nevada-medicaid/care/find-a-doctor.html">https://mss.anthem.com/nevada-medicaid/care/find-a-doctor.html</a></li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem submits NV North &amp; NV South pdf print provider directories for 508c to remediation vendor via electronic submission through vendor tool. Anthem submits to Medicaid Digital Solutions (MDS) team to post on member &amp; provider websites by the 15th of every month. For our paper and online PDF directions the date that provider data extract is pulled is displayed at the bottom of the table of contents page.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<b>Required Actions:</b> None.		



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
20. Provider directories must be made available on the MCO’s website in a machine-readable file and format as specified by the Secretary.  42 CFR §438.10(h)(4) Contract 3.16.5	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Provider directory (provide a link to the website)</li> <li>• Verification that the provider directory is available in a machine-readable file and format</li> </ul> <b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>• 20.P_P Provider Directories: page 3, 16</li> <li>• NV Medicaid Provider Directory North</li> <li>• NV Medicaid Provider Directory South</li> <li>• Link to directories: <a href="https://mss.anthem.com/nevada-medicaid/care/find-a-doctor.html">https://mss.anthem.com/nevada-medicaid/care/find-a-doctor.html</a></li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b> Print pdf directories – Net version (machine-readable) provided.		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
Information for All Members of MCO—Preferred Drug List		
21. The MCO must make available in electronic or paper form the following information about its formulary: <ol style="list-style-type: none"> <li>Which medications are covered (both generic and name brand).</li> <li>What tier each medication is on.</li> <li>Formulary drug lists must be made available on the MCO’s website in a machine-readable file and format as specified by the Secretary.</li> </ol> 42 CFR §438.10(i)(1-3)	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Formulary (provide a link to the website and excerpts of the formulary)</li> <li>• Verification that the electronic formulary is available in a machine-readable file and format</li> </ul> <b>Evidence as Submitted by the MCO:</b>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">Contract 3.14.7.1(D)</p>	<ul style="list-style-type: none"> <li>21.NV Medicaid Pharmacy A03_Formulary Review Process: pages 1-4</li> <li>21.NV Medicaid Pharmacy A15_Pharmacy Program: pages 1-2</li> <li>Anthem Nevada member web site hosting links to PDL and formulary: <a href="https://mss.anthem.com/nevada-medicaid/benefits/pharmacy-benefits.html#/pharmacydruginteraction">https://mss.anthem.com/nevada-medicaid/benefits/pharmacy-benefits.html#/pharmacydruginteraction</a></li> <li>Online searchable formulary including brands, generics, benefits, and coverage tiers. Includes link to Machine Readable File. <a href="https://client.formularynavigator.com/Search.aspx?siteCode=1200880062">https://client.formularynavigator.com/Search.aspx?siteCode=1200880062</a></li> <li>Machine Readable Format - <a href="http://fm.formularynavigator.com/FBO/4/Nevada%20Medicaid%20-%20JSON.json">http://fm.formularynavigator.com/FBO/4/Nevada%20Medicaid%20-%20JSON.json</a></li> <li>21.NV_Medicaid_Pharmacy_PDL</li> <li>21.NV Medicaid Pharmacy Formulary Excerpt</li> <li>21.NV Medicaid Pharmacy online formulary cap</li> </ul>	
<p><b>MCO Description of Process:</b> Documents NV Medicaid Pharmacy online formulary cap and NV Medicaid Pharmacy Formulary Excerpt are from our live system.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard II—Member Rights and Member Information		
Requirement	Supporting Documentation	Score
<b>Information for all Members of MCO—Member Newsletter</b>		
<p>22. <i>The MCO, subject to the prior review and approval of DHCFP, must publish a newsletter for enrolled members at least twice per year.</i></p> <p>a. <i>The newsletter focuses on topics of interest to enrolled members;</i></p> <p>b. <i>The newsletter must be written at an eighth (8th)-grade level of understanding reflecting cultural competence and linguistic abilities.</i></p> <p>c. <i>The MCO must provide a copy of all newsletters to the DHCFP. Additionally, these newsletters and announcements regarding provider workshops must be published on the MCO’s website.</i></p> <p style="text-align: right;">Contract 3.7.8.4</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Examples of member newsletters published during fiscal year (FY) 21</li> <li>Documentation of DHCFP’s approval of member newsletters</li> <li>Evidence that member newsletters are written at the required reading grade level</li> <li>Screen shot of the MCO’s website where member newsletters are posted</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>22.Member Newsletter Interactions: page 4</li> <li>22.Member Fall 2020 Newsletter</li> <li>22.Member Spring 2021 Newsletter</li> <li>22.Member Q3 2020 Newsletter Approval Email</li> <li>22.Member Q2 2021 NL 02 21_Approval Email</li> <li>22. 2164414 1031336NVMESABS Q2 2021 NL 02 21_STATE – State approved content showing grade level in header.</li> <li>22. ANV-MEM-0926-20 NV 2020 Q3 Newsletter STATE – State approved content showing grade level in header.</li> <li>Online Newsletter Link: <a href="https://mss.anthem.com/nevada-medicaid/care/health-and-wellness.html">https://mss.anthem.com/nevada-medicaid/care/health-and-wellness.html</a></li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>





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<b>MCO Description of Process:</b> Anthem posts 2 member newsletters per year, and historically they are released in Q2 and Q3. Newsletters are listed on the NV member website: <a href="https://mss.anthem.com/nevada-medicaid/care/health-and-wellness.html">https://mss.anthem.com/nevada-medicaid/care/health-and-wellness.html</a> .		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		

Standard II— Member Rights and Member Information						
Met	=	21	X	1	=	21
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	22	TotalScore	=		21
Total Score ÷ Total Applicable						= 95%



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Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<b>Definitions</b>		
<p>1. The MCO defines “emergency medical condition” as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <ol style="list-style-type: none"> <li>a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.</li> <li>b. Serious impairment to bodily functions.</li> <li>c. Serious dysfunction of any bodily organ or part.</li> </ol> <p style="text-align: right;">42 CFR §438.114(a)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• III_PP_Emergency_Services_Core_Process: page 20, 2nd paragraph, Nevada exceptions section</li> <li>• III_Member_Handbook: page 42, beginning of Emergency Care section</li> <li>• III_Provider_Manual: page 81 (footer page #), 2nd paragraph of Section 9.9 (Emergency Services)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem’s policy, member handbook, and provider manual definitions align with the federal managed care regulatory definition of an emergency medical condition. Note that the definition within the policy referenced above mirrors the definition within RFP 3260 Section 2 (Acronyms/Definitions).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>2. The MCO defines “emergency services” covered inpatient and outpatient services that are as follows:</p> <ol style="list-style-type: none"> <li>a. Furnished by a provider that is qualified to furnish these services under this Title.</li> </ol>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>b. Needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right;">42 CFR §438.114(a)</p>	<p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>III_PP_Emergency_Services_Core_Process: page 2, 1st paragraph, Definitions section / page 20, 4th paragraph, Nevada exceptions section</li> <li>III_Member_Handbook: page 29, Emergency Services (2nd column)</li> <li>III_Provider_Manual: page 81 (footer page #), 1st paragraph of Section 9.9 (Emergency Services)</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem’s policy, member handbook, and provider manual definitions align with the federal managed care regulatory definition of emergency services.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>3. The MCO defines “poststabilization care services” as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</p> <p style="text-align: right;">42 CFR §438.114(a)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>III_PP_Coverage_for_Post_Stabilization_Care_Services: page 1, 1st paragraph, Definitions section</li> <li>III_Member_Handbook: page 43, 2nd paragraph, Emergency Care section / page 35, Post-Stabilization Care (2nd column)</li> <li>III_Provider_Manual: page 25 (footer page #), Out of Area Care (2nd column)</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<b>MCO Description of Process:</b> Anthem’s policy, member handbook, and provider manual definitions align with the federal managed care regulatory definition of poststabilization care services.		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
Coverage and Payment		
<p>4. The MCO must cover and pay for emergency services, <i>both in and out of state</i>, regardless of whether the provider that furnishes the services has a contract with the MCO.</p> <p>a. <i>No prior or post-authorization can be required for emergency care provided by either network or out-of-network providers.</i></p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.114(c)(1)(i) Contract 3.4.9.2(A-B)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Claim algorithm for emergency services</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>III_PP_Emergency_Services_Core_Process: page 19, 1st paragraph under Nevada exceptions section / page 20, 2nd sentence of 4th paragraph</li> <li>III_Member_Handbook: page 12, Prior Authorization (preapproval) section / pages 42-43, under heading “If you have an emergency...” / page 43 under heading “How to receive health care when you are out of town”</li> <li>III_Provider_Manual: page 25 (footer page #), Out of Area Care (2nd column) / page 81 (footer page #), 1st paragraph of Section 9.9 (Emergency Services)</li> <li>III_NV_ER_Claims_Processing_Instruction</li> <li>III_NV_Reimbursement_Policy_Emergency: pages 1-2</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>III_ER_Services_Paid_Claim_Examples: examples of reimbursed emergency services (no preauth required) for in-state out of network provider, in-state network provider, out-of-state out-of-network provider.</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem covers and pays for emergency services (both in and out of state) regardless of whether the provider is in network. Note that Anthem may require additional medical record documentation in order to determine the appropriate reimbursement amounts. In lieu of claims algorithm, Anthem is submitting claims processing instructions and examples of paid out-of-network emergency service claims with no preauth imposed.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>5. The MCO may not deny payment for treatment obtained under either of the following circumstances:</p> <p>a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in (1), (2), and (3) of the definition of “emergency medical condition” in 42 CFR §438.114(a).</p> <p>b. A representative of the MCO instructs the member to seek emergency services.</p> <p style="text-align: right;">42 CFR §438.114(c)(1)(ii)(A-B) Contract 3.4.9.2(B)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Claim algorithm for emergency services</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>III_PP_Emergency_Services_Core_Process: page 2, sections 3 and 4 of Procedure</li> <li>III_Member_Handbook: page 42, beginning of Emergency Care section</li> <li>III Provider Manual: page 81 (footer page #), 1st two paragraphs and 4th paragraph of Section 9.9 (Emergency Services)</li> <li>III_NV_ER_Claims_Processing_Instruction</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p><b>MCO Description of Process:</b> Anthem’s policy is to not deny payment for Emergency Services and Care if, on the basis of presenting symptoms identified by the member, a prudent layperson who possesses an average knowledge of health and medicine, believed that it was an Emergency Medical or BH Condition. Likewise, Anthem does not deny payment if the member obtained Emergency Services and Care based on instructions of a practitioner or other representative of the health plan.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
Additional Rules for Emergency Services		
<p>6. The MCO may not:</p> <p>a. Limit what constitutes an “emergency medical condition” with reference to 42 CFR §438.114(a), on the basis of lists of diagnoses or symptoms; and</p> <p>b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, MCO, or DHCFP of the member’s screening and treatment within 10 calendar days of presentation for emergency services.</p> <p style="text-align: right;">42 CFR §438.114(d)(1)(i-ii) Contract 3.4.9.2(C)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• III_PP_Emergency_Services_Core_Process: pages 2-3, sections 5, 6 and 12 of Procedure</li> <li>• III_Member_Handbook: page 42, beginning of Emergency Care section</li> <li>• III_Provider_Manual: page 81 (footer page #), 1st two paragraphs and 4th paragraph of Section 9.9 (Emergency Services)</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem’s policy outlines compliance with these provisions and neither our member handbook nor provider manual language limits the definition of emergency medical condition on the basis of diagnoses or symptoms. The list in the handbook is presented only as examples.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<p>7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.</p> <p style="text-align: right;">42 CFR §438.114(d)(2) Contract 3.4.9.2(D)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• III_PP_Coverage_for_Post_Stabilization_Care_Services: page 12, Nevada exceptions section</li> <li>• III_Member_Handbook: page 11, 3rd paragraph under Anthem benefits / page 69, If you receive a bill... section.</li> <li>• III_Provider_Manual: pages 112-113 (footer page #), section 12.10 on Billing Members</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem’s policy aligns with this requirement regarding member not liable for payment of subsequent screening and treatment. The member handbook sections cited note that there are no copays under the program and also outlines how members can request assistance from Anthem if their providers send them a bill. Anthem’s provider manual prohibits balance billing members for amount above what is paid by Anthem for covered services.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 42 CFR §438.114(b) as responsible for coverage and payment.</p> <p style="text-align: right;">42 CFR §438.114(d)(3)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
Contract 3.4.9.2(D)	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>III_PP_Emergency_Services_Core_Process: page 14, section 4 of Procedure</li> <li>III_Member_Handbook: page 12, Prior Authorization (preapproval) section / pages 42-43, under heading “If you have an emergency...”</li> <li>III_Provider_Manual: page 81 (footer page #), section 9.9 Emergency Services, last paragraph</li> </ul>	
<b>MCO Description of Process:</b> Anthem’s policy and provider manual are clear that the determination of the provider actually treating the member is binding upon Anthem. Our member handbook relays the key information that the member needs to know. Namely that prior approval is not needed for emergency services and that they will be able to continue to receive care until their health has stabilized.		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
<b>Coverage and Payment: Poststabilization Care Services</b>		
9. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR §422.113(c). The MCO: <ol style="list-style-type: none"> <li>a. Is financially responsible (consistent with 42 CFR §422.214) for poststabilization care services obtained within or outside the MCO that are pre-approved by a plan provider or other organization representative;</li> <li>b. Is financially responsible for poststabilization care services obtained within or outside the MCO that are not pre-approved by a plan provider or other MCO representative,</li> </ol>	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Workflow for claims review process for poststabilization services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>III_PP_Coverage_for_Post_Stabilization_Care_Services: page 12, Nevada exception section / pages 1-2, Definitions section</li> </ul>	





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Requirement	Supporting Documentation	Score
<p>but administered to maintain, improve, or resolve the member’s stabilized condition if—</p> <ul style="list-style-type: none"> <li>i. The MCO does not respond to a request for pre-approval within one (1) hour;</li> <li>ii. The MCO cannot be contacted; or</li> <li>iii. The MCO representative and the treating physician cannot reach an agreement concerning the member’s care and a plan physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the member until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met; and</li> </ul> <p>c. Must limit charges to members for poststabilization care services to an amount no greater than what the MCO would charge the member if he or she had obtained the services through the MCO. For purposes of cost sharing, poststabilization care services begin upon inpatient admission.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §422.113(c)(2)(i-iv) 42 CFR §422.214 42 CFR §438.114(e) Contract 3.4.10(A-C), (E)</p>	<ul style="list-style-type: none"> <li>• III_Member_Handbook: page 43, 2nd paragraph, Emergency Care section / page 35, Post-Stabilization Care (2nd column)</li> <li>• III_Provider_Manual: page 25 (footer page #), Out of Area Care (2nd column)</li> <li>• III_Non-Notification_Processing_Instruction.pdf: page 1</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem’s policy and provider manual are aligned with the federal requirements regarding coverage criteria for post-stabilization services. Our member handbook relays the key information that the member needs to know (description of what post-stabilization care is and that it is a covered service).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard III—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>10. The MCO’s financial responsibility for poststabilization care services it has not pre-approved ends when—</p> <ol style="list-style-type: none"> <li>a. A plan physician with privileges at the treating hospital assumes responsibility for the member’s care;</li> <li>b. A plan physician assumes responsibility for the member’s care through transfer;</li> <li>c. An MCO representative and the treating physician reach an agreement concerning the member’s care; or</li> <li>d. The member is discharged.</li> </ol> <p style="text-align: right; margin-right: 50px;">42 CFR §422.113(c)(3)(i-iv) 42 CFR §438.114(e) Contract 3.4.10(D)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• III_PP_Coverage_for_Post_Stabilization_Care_Services: page 2, Procedure section d (i-iv)</li> <li>• III_Member_Handbook: page 43, 2nd paragraph, Emergency Care section / page 35, Post-Stabilization Care (2nd column)</li> <li>• III_Provider_Manual: page 25 (footer page #), Out of Area Care (2nd column)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem’s policy and provider manual are aligned with the federal requirements regarding coverage criteria for post-stabilization services. Our member handbook relays the key information that the member needs to know (description of what post-stabilization care is and that it is a covered service).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.  <b>Recommendations:</b> HSAG recommends that the MCO review its provider manual language to include information related to when the MCO’s financial responsibility will end for poststabilization services that have not been pre-approved.</p>		
<p><b>Required Actions:</b> None.</p>		



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<b>Standard III—Emergency and Poststabilization of Services</b>						
<b>Met</b>	=	<b>10</b>	<b>X</b>	<b>1</b>	=	<b>10</b>
<b>Not Met</b>	=	<b>0</b>	<b>X</b>	<b>0</b>	=	<b>0</b>
<b>Not Applicable</b>	=	<b>0</b>				
<b>Total Applicable</b>	=	<b>10</b>	<b>Total Score</b>		=	<b>10</b>
<b>Total Score ÷ Total Applicable</b>					=	<b>100%</b>



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
<b>Delivery Network</b>		
<p>1. The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(b)(1) Contract 3.4.2.7</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Provider contract</li> <li>Analysis of provider network linguistic capabilities</li> <li>Analysis of provider network capabilities to serve members with special health care needs</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>IV_Sample_Provider_Contract: page 25 (2.2.2 and 2.2.3)</li> <li>IV_Nevada_Provider_Manual: page 58 (footer page #) Section 7.2, 4th and 6th bullets / page 16 (footer page #) Section 4.11 / page 73 (footer page #) Section 7.3 first paragraph / pages 65-66 (footer page #s) Section 7.12</li> <li>IV.1_2020_CLAS_Eval: pages 19-22 includes analysis of linguistic capabilities (Provider Demographics: Language Assistance Capability, Provider Cultural Competency)</li> <li>IV_ANT_402_Network Adequacy Report Q1.2021 2021.05.12: Tabs 402a and 402b include ratios and time/distance analysis for specialists (providers serving members with special health care needs)</li> <li>IV_ANT_404 Culture Competency Plan_2021.06.15: Anthem’s cultural competency plan report to DHCFP includes QM program evaluation with review of network capabilities related to specialists. See Network Management section from pages 40-43.</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>IV_Accessibility_Analysis_March2021: Time/distance analysis of specialists (providers serving members with special health care needs) appears throughout but starts on page 86</li> </ul>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
<p>2. The MCO provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.</p> <p style="text-align: right;">42 CFR §438.206(b)(2) Contract 3.4.2.8(E)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Claims algorithm</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>IV_PP_Specialty Referral: page 1, section 1 of the Procedure</li> <li>IV_PP_Access_to_Care_Standards: page 2, PCP definition</li> <li>IV_Nevada_Member_Handbook: page 40 (Services That Do Not Need A Referral) / pages 7-8 (Picking an OB/GYN)</li> <li>IV.2_Womens_Health_Example_Claim</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
<p>3. The MCO provides for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member.</p> <p style="text-align: right;">42 CFR §438.206(b)(3) Contract 3.4.2.10</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Second opinion tracking/analysis</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>IV.3_PP_Second_Opinion: page 5 (Nevada exception)</li> <li>IV_Nevada_Member_Handbook: page 7 (Second opinion)</li> <li>IV_Nevada_Provider_Manual: page 64 (footer page #) Section 7.10</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem’s policy and communications supports our provision for second opinions from a qualified in-network provider, if available, or arrangement for out-of-network second opinion at no cost to the member. Note that Anthem is not able to provide second opinion tracking/analysis as prior authorization is not required for second opinions from in-network providers. There are also not special “second opinion” system or other identifiers related to (or required for) out-of-network authorizations requests that would allow for isolation and automated tracking of all out-of-network second opinion requests.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>4. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for the member, for as long as the MCO's provider network is unable to provide them.</p> <p style="text-align: right;">42 CFR §438.206(b)(4) Contract 3.4.2.9</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Tracking/analysis of services unavailable in network/provider out of network</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>IV_PP_Out_of_Network_Authorization_Process: page 2 (1st paragraph under Procedure section) though note entire</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	<p>Procedure section (pages 2-4) and Nevada exception (page 9) outlines process.</p> <ul style="list-style-type: none"> <li>• IV.4_PP_Out-of-Area_Out-of-Network_Care: page 1 (Policy) though all of core P&amp;P (and Nevada exceptions on pages 11-12) is applicable</li> <li>• IV_Nevada_Member_Handbook: page 6 (Seeing an out-of-plan provider)</li> <li>• IV_NET_3_Network_Adequacy_Assessment: pages 2-7 includes out-of-network analysis. Note that while the document is dated June 2021, the measurement year covered is 2020.</li> </ul>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
<p>5. The MCO requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.</p> <p>a. <i>The MCO must exhaust all out-of-network providers located within 25 miles of the member’s address before contracting with out-of-network providers located over 25 miles from the member’s address.</i></p> <p style="text-align: right;">42 CFR §438.206(b)(5) Contract 3.4.2.9</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• One example of an executed single case agreement</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• IV_PP_Out_of_Network_Authorization_Process: page 2 (1st paragraph under Procedure section) though note entire Procedure section (pages 2-4) and Nevada exception (page 9) outlines process.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>IV_Nevada_Member_Handbook: page 6 (Seeing an out-of-plan provider)</li> <li>IV.5_Executed_Single_Case_Agreement</li> </ul>	
<p><b>MCO Description of Process:</b> If Anthem is not able to locate an in-network provider to meet a member’s needs, Anthem’s Provider Solutions team is engaged to assist and identify an out-of-network option closest to the member that will accept the member.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>6. The MCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.</p> <p style="text-align: right;">42 CFR §431.51(b)(2) 42 CFR §438.206(b)(7)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Network analysis of family planning providers, including a comparison of family planning providers enrolled in Nevada Medicaid and family planning providers contracted with the MCO</li> <li>Claims algorithm</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>IV_PP_Access_to_Care_Standards: page 2 (high volume specialists), page 3 (Specialist Appointments)</li> <li>IV_PP_Standards_Measures_for_Appropriate_Provider_Availability: page 2, page 3 (paragraph 2)</li> <li>IV.6_PP_Appt_After-Hours_And_Telephone_Accessibility: page 3 (c and d)</li> <li>IV_Nevada_Member_Handbook: page 50 (Family planning services) / page 8 (first full sentence)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA





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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>IV_Nevada_Provider_Manual: page 22 (footer page #), Family Planning Services and Supplies</li> <li>IV_NET_1_B-D_Availability of Practitioners: page 1-3, 7 (highlighted text)</li> <li>IV_Anthem Benefits: Excel row 29 of “Business Requirements - Adult” tab outlines in Additional Information column that Family Planning “Must be covered without authorization at any qualified family planning provider, regardless of whether or not they are participating.” This benefits requirement document informs Anthem’s claims configuration.</li> </ul>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
Timely Access		
<p>7. The MCO must do the following:</p> <p>a. Meet and require its network providers to meet DHCFP standards for timely access to care and services, taking into account the urgency of the need for services.</p> <p>i. <i>The MCO has written policies and procedures regarding appointment standards and disseminated the standards to all network providers—Refer to the Access Standards: Appointment Times Checklist.</i></p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Network analysis (e.g., appointment standards)</li> <li>Results of provider monitoring (e.g., secret shopper surveys)</li> <li>One example of corrective action when a provider failed to meet access standards</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
<p>ii. <i>The MCO must assign a specific staff member of its organization to ensure compliance with these standards by the network.</i></p> <p>b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS), if the provider serves only Medicaid members.</p> <p>c. Make services included in the contract available 24 hours a day, seven days a week, when medically necessary.</p> <p>d. Establish mechanisms to ensure compliance by network providers.</p> <p>e. Monitor network providers regularly to determine compliance.</p> <p>f. Take corrective action if there is a failure to comply by a network provider.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(i-vi) Contract 3.4.2.13</p>	<ul style="list-style-type: none"> <li>• HSAG will also use the results of the Access Standards: Appointment Times Checklist.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• IV_PP_Access_to_Care_Standards: entire P&amp;P procedures section applicable</li> <li>• IV_Sample_Provider_Contract: page 25, section 2.2 and 2.2.1</li> <li>• IV_Nevada_Provider_Manual: page 53 (footer page #), Section 6.2 / pages 61-62 (footer page #s), Section 7.3 / page 60 (footer page #), second bullet / pages 66-67 (footer page #s), Section 7.13</li> <li>• IV_NET_2_A-C_Accessibility_of_Appts: entire document applicable to network analysis re: appointment standards and results of provider monitoring</li> <li>• IV.7_Non-Compliance_Letter</li> <li>• IV.7_Appt_Avail_Survey_CAP_Form</li> </ul>	
<p><b>MCO Description of Process:</b> Note that Jackie Ferguson, Director of Provider Experience, is the Anthem staff member responsible for ensuring compliance with timely access standards.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
<b>Steps to Assure Accessibility of Services</b>		
<p>8. <i>The MCO must have written policies and procedures describing how members and providers can obtain urgent coverage after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.</i></p> <p style="text-align: right;">Contract 3.4.2.14</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• IV_PP_Access_to_Care_Standards: page 4, paragraphs 3 and 4</li> <li>• IV.8_PP_Appt_After-Hours_And_Telephone_Accessibility: page 4 (After Hours Care and After Hours Requirements)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<b>Access and Cultural Considerations</b>		
<p>9. The MCO participates in DHCFP’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.</p> <p style="text-align: right;">42 CFR §438.206(c)(2) Contract 3.4.2.15</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Provider materials, such as the provider manual and provider contract</li> <li>• Cultural competency plan</li> <li>• Analysis of provider network linguistic capabilities</li> <li>• Analysis of provider network cultural competence</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• IV.9_PP_Provider_Network_Cultural_Responsiveness: pages 1-3 (entire core policy applicable)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>IV.9_PP_Culturally_and_Linguistically_Appropriate_Service s: Core P&amp;P (pages 1-11) is applicable and page 31 includes Nevada-specific section.</li> <li>IV_PP_Access_to_Care_Standards: page 5, item 1.v</li> <li>IV_Nevada_Provider_Manual: pages 67-69 (footer page #), Section 7.14</li> <li>IV.9_2020_CLAS_Eval: pages 19-21 (Provider Demographics: Language Assistance Capability), pages 21-22 (Provider Cultural Competency)</li> </ul>	
<b>MCO Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
Accessibility Considerations		
10. The MCO must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.  <div style="text-align: right;">             42 CFR §438.206(c)(3)              Contract 3.10.16.7(A-B), 3.14.7.2           </div>	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials such as the provider manual and provider contract</li> <li>Analysis of provider network capability to provide services to members with physical or mental disabilities</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>IV_PP_Access_to_Care_Standards: page 5, item 1.vi</li> </ul>	



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Standard IV—Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>IV_Nevada_Provider_Manual: page 16 (footer page #) Section 4.11 / page 73 (footer page #) Section 7.3 first paragraph / page 66 (footer page #s) first bullet</li> <li>IV_Sample_Provider_Contract: page 28 (4.1)</li> </ul>	
<p><b>MCO Description of Process:</b> Note that analysis documents related to oversight of accessibility are not included. No site assessments were performed in 2020 due to the COVID-19 pandemic.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		

Standard IV—Availability of Services						
<b>Met</b>	=	<b>10</b>	<b>X</b>	<b>1</b>	=	<b>10</b>
<b>Not Met</b>	=	<b>0</b>	<b>X</b>	<b>0</b>	=	<b>0</b>
<b>Not Applicable</b>	=	<b>0</b>				
<b>Total Applicable</b>	=	<b>10</b>	<b>Total Score</b>		=	<b>10</b>
<b>Total Score ÷ Total Applicable</b>					=	<b>100%</b>



**Appendix A. Review of the Standards  
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Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
<b>Basic Rule</b>		
<p>1. The MCO gives assurances to DHCFP and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DHCFP’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).</p> <p>a. Each MCO must submit documentation to DHCFP, in a format specified by DHCFP, to demonstrate that it complies with the following requirements:</p> <p>i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area.</p> <p>ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.207(a);(b)(1-2) Contract 3.7; 3.7.2.11</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Time/distance analysis</li> <li>Member/provider ratio analysis</li> <li>Exceptions approved by DHCFP</li> <li>HSAG will also use the results of the Access Standards: Time/Distance Checklist.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>V_PP_Standards_Measures_for_Appropriate_Provider_Avail ability: entire P&amp;P applicable but regarding State submission see last two paragraphs of page 6</li> <li>V.1_Accessibility_Analysis_March2021</li> <li>V_ANT_402_Network Adequacy Report Q1.2021_2021.05.12</li> <li>V_NET_1_B-D_Availability of Practitioners</li> <li>V_2020_CLAS_Evaluation: pages 8-9, pages 14-22</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem adheres to DHCFP’s template and quarterly frequency for submission of network adequacy documentation. An example State report is enclosed (in addition to other analyses), and the policy outlines Anthem’s standards and processes for monitoring network adequacy. Note that Anthem does not currently have any DHCFP-approved exceptions.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
<b>Timing of Documentation</b>		
<p>2. Each MCO must submit the documentation described in 42 CFR §438.207(b) as specified by DHCFP, but no less frequently than the following:</p> <ul style="list-style-type: none"> <li>a. At the time it enters into a contract with DHCFP.</li> <li>b. On an annual basis.</li> <li>c. At any time there has been a significant change (as defined by DHCFP) in the MCO’s operations that would affect the adequacy of capacity and services, including—               <ul style="list-style-type: none"> <li>i. Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; or</li> <li>ii. Enrollment of a new population in the MCO.</li> </ul> </li> <li>d. <i>Upon request by the DHCFP, the MCO must confirm the network adequacy and accessibility of its provider network and any subcontractor’s provider network.</i></li> </ul> <p style="text-align: right; font-size: small;">42 CFR §438.207(c)(1-3) Contract 3.7.2.11; 3.7.7; 3.16.5</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Most recent annual assurances of adequate capacity and services submission to DHCFP</li> <li>• Assurances of adequate capacity and services submission to DHCFP due to a significant change (if no significant change, indicate in the MCO Description of Process)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• V_PP_Standards_Measures_for_Appropriate_Provider_Avail ability: entire P&amp;P applicable but regarding State submission see last two paragraphs of page 6</li> <li>• V.2_ANT 404 Culture Competency Plan_2021.06.15: Anthem’s annual cultural competency plan report to DHCFP includes QM program evaluation with network adequacy element. See Network Management section from pages 40-43. Network Adequacy section is on page 42.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Note that Anthem did not identify a significant change within the review period that would materially impact our members’ ability to timely obtain needed services.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.  <b>Recommendations:</b> After the interview session, the MCO submitted its Termination Playbook that outlined procedures related to terminations that would affect the MCO’s provider network and access to care, as well as time frames for submitting provider terminations to DHCFP. While this meets the intent of this requirement, HSAG recommends the MCO consider developing a guidance document that details the steps to take if a major change in the MCO’s operations that would affect the adequacy of capacity of services, outside of provider terminations (e.g. changes in benefits). Implementation of these recommendations will be further assessed during future compliance reviews.</p>		



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Standard V—Assurances of Adequate Capacity and Services		
Requirement	Supporting Documentation	Score
<b>Required Actions:</b> None.		

Standard V—Assurances of Adequate Capacity and Services						
Met	=	2	X	1	=	2
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	2	Total Score	=		2
Total Score ÷ Total Applicable						= 100%





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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<b>Care and Coordination of Services for All MCO Members</b>		
<p>1. The MCO must ensure that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity.</p> <p>a. <i>For members with case management needs, the designated PCP is the physician who will manage and coordinate the overall care for the member.</i></p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.208(b)(1) Contract 3.6.1.1(B)(2); 3.6.3.1, and 3.10.20.2(F)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Screen shot of assigned PCP in system</li> <li>ID card with assigned PCP</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI_PP_PCP_Selection_Assignment_Change_Requests: page 1 (PCP definition), page 2 (1st paragraph), page 4 (paragraph 2)</li> <li>VI.1_System_Screenshot_Assigned_PCP</li> <li>VI.1_ID_Card_with_Assigned_PCP</li> <li>VI.1_PP_Case_Manager_Planning_and_Facilitation: pages 2-4</li> <li>VI_Individualized_Care_Plan</li> <li>VI_Welcome_to_CM_Letter-Member_And_Provider</li> <li>VI.1_2020-2021_Complex_CM_Program_Description: pages 30, 32, 36 (footer page #s)</li> <li>VI.1_PP_Member_ID_Cards-NV.pdf: page 1, Purpose section and 1.f of Procedures section</li> <li>VI_Provider_Manual: page 58 (footer page #) sections 7.1 and 7.2 / pages 54-55 (footer page #s) section 6.6</li> <li>VI_Member_Handbook: page 3, Important Phone Numbers / page 5, Picking a primary care provider</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><b>MCO Description of Process:</b> Anthem assigns Members to a PCP upon enrollment if not previously selected. Members are free to change their selection of PCP at any time. Upon enrollment into Case Management, the Member receives a Case Management Welcome Letter with a copy sent to their assigned PCP on file. The Case Manager will facilitate the coordination of the member’s care and ensure communication between the Member, PCP, and other care team members, including specialists and state agencies. When a Member is successfully engaged in Case Management, the PCP receives a copy of the Member’s Individualized Care Plan to collaborate and ultimately sign in agreement as the PCP drives the Member’s care. The Member is also essential in creating the Care Plan, with consent being obtained from the Member before implementation. All CMs have a work mobile phone with a direct contact that Members can call or save into their mobile phones as a favorite so they are able to quickly contact their CM when needed, during Anthem business hours, or leave a confidential voice message for call back. Note also that the Member Handbook includes phone numbers for contacting Case Management and Disease Management.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>2. The MCO must coordinate the services the MCO furnishes to the member:</p> <ol style="list-style-type: none"> <li>a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;</li> <li>b. With the services the member receives from any other MCO, PIHP, or PAHP;</li> <li>c. With the services the member receives in FFS Medicaid; and</li> <li>d. With the services the member receives from community and social support providers.</li> </ol> <p style="text-align: right; margin-right: 50px;">42 CFR §438.208(b)(2)(i-iv) Contract 3.4.14</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• VI.2_2020-2021_Complex_CM_Program_Description: pages 42-44 (footer page #s), Care Transitions between Settings</li> <li>• VI.2_PP_Concurrent_Review_On-site_Review: pages 2-3 (Discharge Planning), pages 9-10 (paragraph 5a Discharge Planning)</li> <li>• VI.2_PP_UM_Clinicians_Responsibilities: pages 1-2</li> <li>• VI.2_PP_Coordination_of_Care_NV: pages 2-3 (paragraph 6)</li> <li>• VI.2_PP_Case_Manager_Planning_and_Facilitation: pages 3-4</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI.2_PP_Transition_of_Members_Care_to_Health_Plan-NV: pages 1-2 (paragraph 1)</li> <li>VI.2_PP_Post_Discharge_Management – pages 1-2</li> </ul>	
<p><b>MCO Description of Process:</b> Case Managers receive a monthly Transition of Care (TOC) report that lists newly enrolled members who were previously enrolled in Case Management (CM) or in need of CM services with other MCEs. CM will contact members identified as needing CM and evaluate for level of services needing, such as Care Coordination or higher level Case Management. Anthem provides Continuity of Care for up to 90 days with authorizations previously approved with other MCOs, while working to secure an in-network service or an agreement with current treating providers. Anthem’s Concurrent Review Utilization Management team will monitor member’s while inpatient and facilitate a safe discharge plan with the facility, including our CM team when appropriate. Member Services is also available for members newly enrolled and not in need of Care Management services. All of our Care Managers, as well as Member Services, can provide information for our members on available Anthem benefits and community resources, as well as the authorization process for needed services.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>3. The MCO must ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.</p> <p style="text-align: right;">42 CFR §438.208(b)(5) Contract 3.7.3.1(F); 3.8</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Oversight of provider medical record practices, such as audits, site visits, etc.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.3_PP_Standards_for_Medical_Record_Review: pages 1-3</li> <li>VI.3_PP_Medical_Record_Review_Requirements-NV: entire P&amp;P is relevant</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI_Provider_Manual: pages 69-71 (footer page #) 7.15 Member Records</li> <li>VI.3_AMRR Tool</li> <li>VI.3_AMRR Interpretive Guidelines</li> <li>VI.3_2020_AMRR_Report_Final_Results_12.18.20</li> <li>VI.3_Notification of AMRR</li> <li>VI.3_AMRR_Provider_Audit_Results_Letter_Template</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem requires maintenance of medical records in a manner that is current and organized and permits effective and confidential patient care and quality review. Medical record standards and sharing requirements are outlined for providers in our manual which (along with our medical record review policy) describes our process for reviewing medical records. The review tool, guidelines, 2020 results, and sample notice/results letters are included to support evidence of compliance.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
Health Needs Assessment Screening		
<p>4. <i>The MCO must have mechanisms in place to screen and identify members potentially eligible for case management services. These mechanisms include:</i></p> <p style="margin-left: 20px;">a. <i>Administrative data review (e.g., diagnosis, cost threshold, and/or service utilization) and may also include:</i></p> <p style="margin-left: 40px;">i. <i>Telephone interviews;</i></p> <p style="margin-left: 40px;">ii. <i>Mail surveys;</i></p> <p style="margin-left: 40px;">iii. <i>Provider/self-referrals; or</i></p> <p style="margin-left: 40px;">iv. <i>Home visits.</i></p> <p style="text-align: right; margin-right: 20px;">Contract 3.10.20.2(A)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking and reporting mechanisms for the method of identification of members who are potentially eligible for case management services</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.4_PP_Case_Management_Program_Case_Identification: pages 1-3</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI.4_2020-2021_Complex_CM_Program_Description: pages 27-29 (footer page #s)</li> <li>VI.4_2021_MCS_Program_Description: pages 5, 18, 31 (footer page #s)</li> <li>VI.4_CI3_User_Guide</li> <li>VI.4_CI3_List_ScreenShots</li> <li>VI.4_PP_Children_with_Special_Health_Care_Needs_NV: page 1</li> <li>VI.4_PP_Coordination_of_Care_NV: pages 1-4</li> <li>VI.4_PP_Identification_and_Monitoring_for_Special_Health_Care_Needs: page 2</li> <li>VI.4_PP_Provider_Automated_Referrals_to_Case_Management: pages 1-2</li> <li>VI.4_Snapshot_CM_Identification_Referrals_Guide</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem has a predictive modeling tool in place to identify members who are potentially eligible for Case Management services. Other mechanisms are also available for identification and include information from: criteria identified during the member welcome call; member phone calls; inpatient hospital stays; prior authorization requests; CSHCN (Children with Special Health Care Needs) reporting; ER utilization information; provider referrals; and claims data. We have included an overview and screenshots of the CI3 (Chronic Illness Intensity Index) which houses member-level data used to identify members who may be in need of Care Management services. My Advocate platform, which outreaches to our pregnant members, utilizes inter-active voice response outreach and updates members on their health status, as well as provides an app and website as resources. My Advocate will help connect pregnant members with our OB Case Management team by means of completing the OB Screening tool and prompting OB RNs to call members directly once identified.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<p>5. The MCO must make a best effort to conduct an initial screening of each member’s needs within ninety (90) days of the effective date of enrollment for all new members.</p> <p>a. <i>Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within thirty (30) days;</i></p> <p>b. <i>The MCO must document at least three (3) attempts to conduct the screen. If unsuccessful the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished with in the first one hundred and twenty (120) days.</i></p> <p>c. <i>Face-to-face assessments shall be conducted, as necessary. The goals of the assessment are to identify the member’s existing and/or potential health care needs and assess the member’s need of case management services.</i></p> <p>d. <i>The MCO will submit their Health Needs Assessment Screening form/s and data to the DHCFP upon request.</i></p> <p style="text-align: right; font-size: small;">42 CFR §438.208(b)(3) Contract 3.10.20.2(B)(1)(a-b)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Initial Health Needs Assessment Screening tool template</li> <li>Internal tracking mechanisms</li> <li>HSAG will also use results from the Care Management File Review.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.5_PP_Case_Manager_Assessment: page 8</li> <li>VI.5_PP_Identification_and_Monitoring_for_Special_Health_Care_Needs: page 2</li> <li>VI.5_PP_Case_Management_Program_Case_Identification: page 2</li> <li>VI.5_NV_Pursuant_HNA_Questions</li> <li>VI.5_NV_Pursuant_HNA_Additional_Questions</li> <li>VI.5_OB_High_Risk_Screener</li> <li>VI.5_Pursuant_HNA_Tracking_Report_May_2021</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem has policies that establish the principles for delivery and implementation of health risk screening tool(s) for Case Management. Screenings and/or assessments are available both telephonically and in-person, as necessary. Within 30 days of Enrollment, a welcome call is placed to all members that provide a phone number. An assessment is done of knowledge of benefits and of current needs. If clinical need is identified, then member is triaged for the appropriate program.</p>		
<p><b>HSAG Findings:</b> The case file review confirmed that the MCO did not consistently conduct three attempts to complete the initial health risk screening. MCO staff members explained that they internally identified opportunities for improving this process and are working with their vendor to remediate the identified gaps.</p>		



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Requirement	Supporting Documentation	Score
<p><b>Recommendations:</b> HSAG recommends that the MCO consult with DHCFP regarding the 834-enrollment file and if it includes indicators for members who are identified as pregnant or having a special health care need.</p>		
<p><b>Required Actions:</b> The MCO must make a best effort to conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new members. Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within 30 days. The MCO must document at least three attempts to conduct the screening. If unsuccessful, the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.</p>		
<p>6. The MCO must share with DHCFP or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.208(b)(4) Contract 3.4.14.1(b)(4)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Two case examples of the MCO sharing assessment results: one with another MCE serving the member and one with DHCFP</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.6_PP_Continuity_of_Care_Core_Process: pages 28-29</li> <li>VI.6_PP_Transition_of_Members_Care_to_Health_Plan-NV: pages 1-2</li> <li>VI.6_2020-2021_Complex_CM_Program_Description: page 33</li> <li>VI.6_Anthem_to_HP_N_Transition_of_Care_Form</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem has a defined process to identify and manage care between various provider settings. The process is designed to prevent problems in the transition to the next care setting and enhance communication with members and providers. Anthem is providing one example of a Transition of Care form sent to another MCO. It is not common for members receiving case management to leave the plan and transition to another plan or fee-for-service.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
<p><b>Recommendations:</b> HSAG recommends that the MCO consult with DHCFP regarding processes for the exchange of information between the MCO and DHCFP when a member transitions to or from fee-for-service, for example sharing of transition-of-care forms and open authorizations.</p>		
<p><b>Required Actions:</b> None.</p>		
Comprehensive Assessment		
<p>7. The MCO must implement mechanisms to comprehensively assess each Medicaid member identified by DHCFP and identified to the MCO by DHCFP as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.</p> <p>a. <i>The assessment was completed by a physician, physician’s assistant, registered nurse (RN), licensed practical nurse, licensed social worker, or a graduate of a two- or four-year allied health program.</i></p> <p>b. <i>If the assessment was completed by another medical professional, there was documented oversight and monitoring by either a RN or physician.</i></p> <p style="text-align: right;">42 CFR §438.208(c)(1) Contract 3.10.20.2(C)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• VI.7_2020-2021_Complex_CM_Program_Description: pages 14-16, 30-32, 39 (footer page #s)</li> <li>• VI.7_PP_Children_with_Special_Health_Care_Needs_NV: page 2</li> <li>• VI.7_PP_Identification_and_Monitoring_for_Special_Health_Care_Needs: page 2</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem conducts an initial comprehensive assessment to determine the need for case management services in conjunction with chart reviews, including utilization history and trends. If members are identified as having a special health care need, they are enrolled in our Special Health Care Need (SHCN) program and a comprehensive assessment with corresponding care plan are reviewed with the Member and their PCP.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		





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Requirement	Supporting Documentation	Score
<p>8. <i>The comprehensive assessment evaluated all the following for the member.</i></p> <ul style="list-style-type: none"> <li>a. <i>Physical health</i></li> <li>b. <i>Comorbid conditions</i></li> <li>c. <i>Behavioral health</i></li> <li>d. <i>Psycho-social</i></li> <li>e. <i>Environmental</i></li> <li>f. <i>Community support needs</i></li> </ul> <p style="text-align: right; margin-right: 100px;">Contract 3.10.20.2(C)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use results from the Care Management File Review</li> <li>• Comprehensive Assessment Template</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• VI.8_PP_Case_Manager_Assessment: pages 3-4</li> <li>• VI.8_Adult_Health_Risk_Assessment</li> <li>• VI.8_OB_Health_Risk_Assessment</li> <li>• VI.8_Pediatric_Health_Risk_Assessment</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> The initial comprehensive health assessment for adults, pediatrics, and pregnant members evaluate physical health, comorbid conditions, behavioral health, psycho-social, environmental, and community support needs. The assessments are currently loaded in Anthem’s CareCompass system, which is our CM software, with anticipation of new platform migration within the next 6 months. In addition to the comprehensive health assessments, additional detailed assessments are available if indicated for certain diagnoses such as asthma, diabetes or cancer.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>9. <i>The MCO provided information to members and their PCP that they have been identified as meeting the criteria for case management, including their enrollment into case management services.</i></p> <p style="text-align: right; margin-right: 100px;">Contract 3.10.20.2.1(C); 3.10.20.2(C)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use results from the Care Management File Review</li> <li>• Notification and/or welcome letter template</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• VI.9_PP_Case_Manager_Planning_and_Facilitation: pages 4-5</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI.9_PP_Case_Manager_Role_and_Function_in_Complex_CM: pages 2, 4</li> <li>VI_Welcome_to_CM_Letter-Member_And_Provider</li> </ul>	
<p><b>MCO Description of Process:</b> Upon enrollment into Case Management, the Member receives a Case Management Welcome Letter with a copy sent to their assigned PCP on file. The Case Manager will facilitate the coordination of the member’s care and ensure communication between the Member, PCP, and other care team members, including specialists and state agencies. When a member is successfully engaged in Case Management, the PCP receives a copy of the Member’s Individualized Care Plan to collaborate and ultimately sign in agreement as the PCP drives the Member’s care. The Case Manager works with the Primary Care Physician (PCP), non-medical assistance programs and other professionals to develop an ongoing, long-term or discharge care plan as appropriate.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
Care Plan		
<p>10. <i>Based on the assessment, the MCO coordinated the placement of the member into case management and developed a person-centered care plan within ninety (90) calendar days of membership.</i></p> <p style="text-align: right;">Contract 3.10.20.2(E)(1)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use results from the Care Management File Review</li> <li>Tracking and reporting mechanisms for timely completion of the care plan</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.10_PP_Case_Manager_Assessment: page 8</li> <li>VI.10_PP_Case_Manager_Planning_and_Facilitation: page 1 (Timeframe)</li> <li>VI.10_Care_Plan_Outcomes_Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI.10_Care_Plan_Tracking_System_Screenshot: Note this is current screen shot of system as example only.</li> <li>VI.10_OB_Individualized_Care_Plan</li> <li>VI.10_PH_Individualized_Care_Plan</li> <li>VI.10_Individualized_Care_Plan</li> </ul>	
<p><b>MCO Description of Process:</b> Following the initial assessment, a care plan is developed with the member that includes both short- and long-term goals as well as identifying any barriers. The case management plan is implemented by the Case Manager in collaboration with the participating provider, member, and members’ family and healthcare team to provide quality healthcare and services in a coordinated, cost-effective manner.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>11. <i>There is evidence that the following individuals were actively involved in the development of the care plan:</i></p> <ul style="list-style-type: none"> <li>a. <i>Member</i></li> <li>b. <i>Member’s designated formal and informal supports</i></li> <li>c. <i>Member’s PCP</i></li> </ul> <p style="text-align: right;">Contract 3.10.20.2(E)(1)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI_Individualized_Care_Plan: page 2 (field for physician signature)</li> <li>VI.11_PP_Coordination_of_Care_NV: pages 2-3</li> <li>VI.11_PP_Case_Manager_Assessment: page 2</li> <li>VI.11_PP_Case_Manager_Planning_and_Facilitation: pages 4-5</li> <li>VI_Welcome_to_CM_Letter-Member_And_Provider</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> The care plan is developed with the member/member’s representative and PCP. Care Plans are sent to the PCP for review/revision and approval and sent back to the Nurse Case Manager.</p>		



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Requirement	Supporting Documentation	Score
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p> <p><b>Recommendations:</b> While the case files included documentation that the care plan was faxed to a member’s primary care provider (PCP), the actual communication was not consistently uploaded or attached to the member’s record. As such, HSAG recommends that the MCO provide additional training to care managers to ensure all communications are included in a member’s record.</p>		
<b>Required Actions:</b> None.		
<p>12. <i>The care plan reflects the member’s:</i></p> <ul style="list-style-type: none"> <li>a. <i>Primary medical diagnosis and other health conditions.</i></li> <li>b. <i>Psychological and community support needs.</i></li> <li>c. <i>Specific individualized interventions to meet the member’s assessed needs.</i></li> </ul>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• VI_Individualized_Care_Plan.pdf</li> <li>• VI.12_PP_Case_Manager_Assessment: pages 2-4</li> <li>• VI.12_PP_Complex_Case_Management: page 2</li> <li>• VI.12_PP_Case_Manager_Planning_and_Facilitation: pages 3-4, 6</li> <li>• VI.12_PP_Member_Management_by_Disease_Management: page 4 (paragraphs 8 and 9)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Following the initial assessment, a care plan is developed with the member that reflects the member’s primary medical diagnosis as well as other health conditions and includes both short- and long-term goals and identifying any barriers. The Case Manager also coordinates the services of contracted health and behavioral providers and community agencies to ensure effective implementation of the member’s plan of care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<b>Required Actions:</b> None.		



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Requirement	Supporting Documentation	Score
<p>13. <i>Development and implementation of a care plan includes coordination with State and county agencies, such as Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFSS), Governor’s Office of Consumer Health Assistance (GovCHA), Division of Public and Behavioral Health (DPBH), Division of Welfare and Supportive Services (DWSS), and Substance Abuse Prevention and Treatment Agency (SAPTA) as well as other public assistance programs, such as the Women, Infants, and Children (WIC) program; teen pregnancy programs; parenting programs; and child welfare programs.</i></p> <p style="text-align: right;">Contract 3.10.20.1(D)(2)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.13_2020-2021_Complex_CM_Program_Description: pages 4-6, 37 (footer page #s)</li> <li>VI.13_2021_MCS_Program_Description: pages 13, 27, 34 (footer page #s)</li> <li>VI.13_PP_Continuity_of_Care_Core_Process: page 27 (Nevada exception)</li> <li>VI.13_PP_Case_Manager_Assessment: page 4</li> <li>VI.13_PP_Case_Manager_Planning_and_Facilitation: pages 3-4</li> <li>VI.13_PP_Member_Management_by_Disease_Management: pages 4-5 (paragraph 11)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> In addition to the development of a care plan, the Case Manger provides the member with assistance (placing a referral on the member’s behalf or providing contact information for the member to outreach) to State and community agencies such as WIC, Nurse Family Partnership, Ryan White Foundation, Housing Authority. Care Managers work with all entities of the Member’s treatment team to provide the highest quality, and most cost-effective care possible.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<p>14. <i>The MCO continuously monitors the member’s progress, reevaluates the member’s care needs, and adjusts the level of case management services accordingly.</i></p> <p style="text-align: right;">Contract 3.10.20.2(D)(1)(c)(f)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.14_PP_Case_Manager_Role_and_Function_in_Complex_CM: page 3 (Monitoring/Evaluation)</li> <li>VI.14_PP_Case_Manager_Assessment: page 5</li> <li>VI.14_PP_CM_Monitoring_Follow-Up_Evaluation: pages 2-4</li> <li>VI.14_PP_Complex_Case_Management.pdf: page 3</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> The member’s case is reviewed in a multidisciplinary group including Medical Directors at least every 90 days. Care plans are reviewed every 30 days or more frequently based on member’s needs.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>15. <i>The MCO identified gaps between care recommended and actual care provided, and proposed and implemented interventions to address gaps in care.</i></p> <p style="text-align: right;">Contract 3.10.20.2(D)(1)(d-e)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use results from the Care Management File Review.</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.15_2020-2021_Complex_CM_Program_Description: pages 4-5, 30, 39 (footer page #s)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI.15_PP_CM_Monitoring_Follow-Up_Evaluation: pages 3-4</li> <li>VI.15_PP_Complex_Case_Management.pdf: page 2 (Member Engagement Process)</li> <li>VI.15_PP_Case_Manager_Planning_and_Facilitation: pages 2, 6</li> <li>VI.15_PP_Member_Management_by_Disease_Management: page 4 (paragraph 9)</li> </ul>	
<p><b>MCO Description of Process:</b> During the member’s initial assessment and on-going communication, gaps in care are identified, addressed and interventions are provided to bridge the gaps and/or barriers to care. Care plans and follow-up documentation support interventions implemented as well as any new gaps or barriers identified.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>16. <i>The MCO:</i></p> <p>a. <i>Has ongoing communication regarding the status of the care plan with the PCP or designee (such as a qualified health professional).</i></p> <p>b. <i>Made revisions to the clinical portion of the care plan in consultation with the PCP.</i></p> <p style="text-align: right;">Contract 3.10.20.2(E)(1)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use results from the Care Management File Review.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.16_2020-2021_Complex_CM_Program_Description: pages 6, 34-36, 38 (footer page #s)</li> <li>VI.16_PP_Case_Manager_Assessment: pages 4-5, Collaboration section</li> <li>VI.16_PP_CM_Monitoring_Follow-Up_Evaluation: pages 1 (Monitoring and Follow-Up) and 4 (2nd paragraph of page)</li> </ul>	



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI.16_PP_Case_Manager_Planning_and_Facilitation: pages 2-3 (Collaborative Input) and 4 (Physician Communication)</li> <li>VI_Individualized_Care_Plan</li> <li>VI_Provider_Manual: page 55 (footer page #), paragraph prior to CSHCN section</li> </ul>	
<p><b>MCO Description of Process:</b> Treatment plans are sent to the Provider for review/revision and approval and sent back to the nurse. Member’s case is reviewed in a multidisciplinary group including Medical Directors at least every 90 days. Care plans are reviewed every 30 days or more frequently based on member’s needs.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.  <b>Recommendations:</b> The MCO’s policy lacked specificity in processes for ensuring ongoing communication regarding the status of the care plan with the PCP and making revisions to the clinical portion of the care plan in consultation with the PCP. HSAG recommends that the MCO update its policy to identify criteria or guidelines for care managers as it relates to the requirements of this element.</p>		
<p><b>Required Actions:</b> None.</p>		
Direct Access to Specialists		
<p>17. For members with special health care needs determined through an assessment (consistent with 42 CFR §438.208[c][2]) to need a course of treatment or regular care monitoring, the MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.</p> <p style="text-align: right;">42 CFR §438.208(c)(4) Contract 3.4.7.2</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>VI.17_PP_Specialty Referral.pdf: page 1, section 1 of the Procedure</li> <li>VI_PP_PCP_Selection_Assignment_Change_Requests: page 3, paragraph 4</li> <li>VI.17_PP_Children_with_Special_Health_Care_Needs_NV: page 2, section 2.e</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA





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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>VI_Member_Handbook: pages 5-6, Picking a primary care provider (starting at bottom of page)</li> <li>VI_Provider_Manual: page 63 (footer page #) section 7.8</li> </ul>	
<p><b>MCO Description of Process:</b> While members are encouraged to coordinate all specialty care with their PCP, PCP referrals are not required and all members are allowed direct access to participating specialists. Members with disabilities, chronic conditions, or complex conditions are also allowed to choose a specialist to serve as their PCP if the specialist agrees to do so.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		

Standard VI—Coordination and Continuity of Care						
Met	=	16	X	1	=	16
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	17	Total Score		=	16
Total Score ÷ Total Applicable					=	94%



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>Coverage</b>		
<p>1. The MCO must ensure that services identified in 42 CFR §438.210(a)(1) be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under FFS Medicaid, as set forth in §440.230, and for members under the age of 21, as set forth in subpart B of Part 441.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.210(a)(1-2) 42 CFR §440.230 42 CFR Part 441 Contract 3.4.2.1</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 01. PP Pre-Certification of Requested Services – Core Process pgs. 3-6, 33 (The health plan must furnish...”)</li> <li>• 01. PP EPSDT Services – Core Policy pgs. 4-6, 9</li> <li>• 01. PP Clinical Criteria for Utilization Management Decisions – Core Process pgs. 5-7</li> <li>• 01. PP Emergency Services – Core Process pg. 19</li> <li>• Anthem Benefits; All</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> The Nevada Benefits document contains all of the benefit limits that are configured into our core claims payment system (Facets). Each benefit limit is cited with a source to indicate where the benefit limit is coming from. In addition, benefit limits that are configured into Facets, Anthem uses the Medicaid Service Manual (MSM) as a resource for benefits questions and follows the benefit limits contained in the MSM. The information showing that Anthem’s benefits are the same in amount, duration, and scope is relayed to providers through the Provider Manual. All authorized services are outlined by each plan and deemed medically necessary by the guideline provided by the plan or state requirements.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p> <p><b>Recommendations:</b> As indicated throughout the interview session, HSAG had challenges reviewing the Health Care Management Denial – Core Process policy as it contained discrepancies between corporate-wide sections and the State-specific sections and was not appropriately formatted. HSAG recommends the MCO comprehensively review this policy and ensure that the language within the policy complies with federal requirements under 42 CFR §438 and be formatted to be a usable tool for MCO staff members to understand the requirements related to coverage and authorization of services.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>2. The MCO—</p> <p>a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.</p> <p>b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.210(a)(3)(i-ii) Contract 3.4.2.1–3.4.2.2</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Utilization management plan</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>02. PP Clinical Criteria for Utilization Management Decisions – Core Process pgs. 5-7</li> <li>02. PP EPSDT Services – Core Policy pgs. 4-6, 13</li> <li>02. PP Health Care Management Denial – Core Process pg. 6</li> <li>02. PP Pre-Certification of Requested Services – Core Process pgs. 3-6, 33</li> <li>02. 2021 NV UMPD_final pgs. 6, 10, 12</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem has configured benefit limits for services based on the NV MSM. Medical Policies and Clinical Guidelines are required to be implemented consistently across the organization. MP/CUMGs and the MCG updates will continue to be reviewed by our Medical Policy and Technology Assessment Committee and appropriate Subcommittees.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>3. The MCO may place appropriate limits on a service—</p> <p>a. On the basis of criteria applied under the State plan, such as medical necessity; or</p> <p>b. For the purpose of utilization control, provided that—</p> <p style="margin-left: 20px;">i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);</p> <p style="margin-left: 20px;">ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Utilization management plan</li> <li>Member materials, such as the member handbook</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>03. 2021 UMPD Final pgs. 11-13, 22</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>(LTSS) are authorized in a manner that reflects the member’s ongoing need for such services and supports; and</p> <p>iii. Family planning services are provided in a manner that protects and enables the member’s freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.</p> <p style="text-align: right;">42 CFR §438.210(a)(4)(i-ii) Contract 3.4.2.3</p>	<ul style="list-style-type: none"> <li>• 03. PP Clinical Criteria for Utilization Management Decisions – Core Process pgs. 5-6, 24</li> <li>• 03. PP Health Care Management Denial – Core Process pgs. 5-6</li> <li>• 03 PP Emergency Services – Core Process pgs. 2, 19</li> <li>• Anthem Benefits: Entire document but Family Planning noted on row 29 of Business Requirements - Adult tab.</li> <li>• 03. PPProhibUseofFincalIncentivesWhenMakeMedNecessityDeterminations pgs. 1, 6</li> <li>• 03. Member Handbook pgs. 50 (Family planning services), 30 (Family Planning), 11 (What Does Medically Necessary Mean), 12 (How We Make Decisions About Your Care). The Anthem covered services table that begins on page 13 also specifies where limits apply.</li> <li>• 03. MCS Program Description: pages 30-31 (footer page #s)</li> <li>• 03. Pregnancy and Beyond Resource Guide_ENG: pages 20-23 (PDF page #s)</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem has configured benefit limits for services based on the NV MSM. Medical Policies and Clinical Guidelines are required to be implemented consistently across the organization. MP/CUMGs and the MCG updates will continue to be reviewed by our Medical Policy and Technology Assessment Committee and appropriate Subcommittees. The Provider Manual outlines covered services and practice guidelines that address prevention, diagnosis, and treatment of health including information regarding Family planning services. LTSS services are carved out to the LTSS team with DHCFP.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<p>4. The MCO specifies what constitutes “medically necessary services” in a manner that—</p> <p>a. Is no more restrictive than that used in the DHCFP Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in DHCFP statutes and regulations, the DHCFP Plan, and other DHCFP policy and procedures; and</p> <p>b. Addresses the extent to which the MCO is responsible for covering services that address:</p> <p>i. The prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability.</p> <p>ii. The ability for a member to achieve age-appropriate growth and development.</p> <p>iii. The ability for a member to attain, maintain, or regain functional capacity.</p> <p>iv. The opportunity for a member receiving LTSS to have access to the benefits of community living, achieve person-centered goals, and live and work in the setting of their choice.</p> <p style="text-align: right; font-size: small;">42 CFR §438.210(a)(5)(i-ii) Contract 3.4.2.4</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>04. PP Pre-Certification of Requested Services - Core Process pg 33</li> <li>04. PP Clinical Criteria for Utilization Management Decisions – Core Process pgs. 1-2, 4-7, 24</li> <li>04. PP EPSDT Services – Core Policy pgs. 4-6, 9</li> <li>04. PP Children with Special Health Care Needs – NV pg. 2</li> <li>04. Member Handbook pgs. 11 (What Does Medically Necessary Mean), 12 (How We Make Decisions About Your Care). Note that Anthem covered services table beginning on page 13 describes the extent to which Anthem is responsible for covering services.</li> <li>04. Provider Manual pg. 16 (footer page #). Anthem covered services are outlined beginning on pg 17.</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Medical Policies and Clinical Guidelines are required to be implemented consistently across the organization. MP/CUMGs and the MCG updates will continue to be reviewed by our Medical Policy and Technology Assessment Committee and appropriate Subcommittees.</p> <p>Clinical Review Hierarchy:</p> <ul style="list-style-type: none"> <li>o Federal and State mandates (manuals, contract, and policies) <ul style="list-style-type: none"> <li>- Member benefits (contract language, including definitions and specific contract provisions/exclusions)</li> </ul> </li> </ul>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>- ASAM-BH Criteria               <ul style="list-style-type: none"> <li>o Anthem Medical Policies</li> <li>o Ingenio Clinical Guidelines</li> <li>o AIM Clinical Guidelines</li> <li>o Anthem Clinical UM Guidelines</li> <li>o MCG care guidelines or InterQual as applicable</li> </ul> </li> </ul> <p>LTSS services are carved out to the LTSS team within DHCFP.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p> <p><b>Recommendations:</b> Based on the discussion during the interview session, MCO staff members confirmed responsibility for covering certain LTSS, such as personal care and home health services when medically necessary for its membership. As such, HSAG recommends the MCO review all LTSS-related requirements indicated in federal rule under 42 CFR §438 to ensure its program documentation fully supports compliance. HSAG further recommends the MCO train its staff members to ensure understanding of the MCO’s responsibilities related to LTSS, even though the LTSS membership through waiver services is covered under Medicaid fee-for-service.</p>		
<p><b>Required Actions:</b> None.</p>		
Authorization of Services		
<p>5. For the processing of requests for initial and continuing authorizations of services, the MCO shall—</p> <ul style="list-style-type: none"> <li>a. Have in place, and follow, written policies and procedures.</li> <li>b. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.</li> <li>c. Consult with the requesting provider for medical services when appropriate.</li> <li>d. Authorize LTSS based on a member's current needs assessment and consistent with the person-centered service plan.</li> </ul>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Results of interrater reliability (IRR) activities</li> <li>• One case example of a peer-to-peer (P2P) consult</li> <li>• Workflow to authorize LTSS consistent with the person-centered service plan (PCSP)</li> <li>• HSAG will also use the results of the service authorization denial file review.</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>e. Ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs.</p> <p style="text-align: right;">42 CFR §438.210(b)(1-2) Contract 3.4.2.5</p>	<p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>05. PP Pre-Certification of Requested Services – Core Process: Entire core P&amp;P (pgs 1-9) and NV exception (pg 33) applies to written P&amp;P for processing of requests for authorizations. Pg 3 references consult with requesting provider.</li> <li>05. PP_Associates Performing Utilization Reviews - Core Process pgs 3, 8</li> <li>05. PP Health Care Management Denial – Core Process pgs. 6, 8-11</li> <li>05. PP Inter-Rater Reliability IRR Assessments pgs 1-3</li> <li>05. MASTER Nevada UM Eval 2020 pgs. 16-18</li> <li>05. BH IRR 2020</li> <li>05. Anthem_NV Medicaid_Pharmacy_IRR</li> <li>05. Sample-UM P2P – pg 9</li> <li>05. Member Handbook pg. 12</li> </ul>	
<p><b>MCO Description of Process:</b> Anthem has established UM concurrent and pre-authorization procedures. Concurrent and pre-authorization decisions are made by qualified associates with relevant clinical experience/credentials. Clinical associates will consult with treating physicians as needed in order to determine medical necessity and document authorization decisions in the member’s Facets records. Medical necessity decisions are made in accordance to established clinical guidelines available through Anthem-approved sources. These sources include the Nevada MSM, Anthem Policies and Clinical Guidelines, InterQual, MCG and/or ASAM BH criteria. Anthem utilizes an annual IRR process to ensure consistent application of review criteria for authorization decisions. LTSS services are carved out to the LTSS team within DHCFP.</p> <p>Note – The IRR-related documentation is not strictly within the period for this review as Anthem’s non-pharmacy IRRs are done in June and July with results available in the following March.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Requirement	Supporting Documentation	Score
<b>Notice of Adverse Benefit Determination</b>		
<p>6. The MCO must notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member’s notice must meet the requirements of §438.404. The notice must explain the following:</p> <p>a. The adverse benefit determination (ABD) the MCO has made or intends to make.</p> <p>b. The reasons for the ABD, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s ABD. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits and <i>the specific regulations that support, or the change in federal or State law that requires the action.</i></p> <p>c. The member’s right to request an appeal of the MCO’s ABD, including information on exhausting the MCO’s one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c).</p> <p>d. The procedures for exercising the rights specified in 42 CFR §438.404(b).</p> <p>e. The circumstances under which an appeal process can be expedited and how to request it.</p> <p>f. The member’s right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with DHCFP</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• ABD notice template</li> <li>• HSAG will also use the results of the service authorization denial file review.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 06. PP Health Care Management Denial - Core Process pgs 12-13, 39</li> <li>• 06. ANV-MEM-0406-18 NV QM Initial Denial Ltr Upd FINAL.docx</li> <li>• 06. ANV-MEM-0713-19 NV Member Denial Letter Due to TAT ENG FINAL.DOCX</li> <li>• 06 Appeal Rights and Continuation Attachments</li> <li>• 06. NVUM0016 NV Provider Admin Denial Letter.doc</li> <li>• 06. LTR NVUM0016 Provider Admin Denial in MACESS</li> <li>• 06. Provider Manual pgs. 44-48 (footer page #s)</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>





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<p>policy, under which the member may be required to pay the costs of these services.</p> <p style="text-align: center;">42 CFR §438.402(b-c).            42 CFR §438.404(b)(1-6)            Contract 3.13.4.3</p>		
<p><b>MCO Description of Process:</b> Anthem sends out notice of action to members and providers for any full or partial denial of services. The notice of action contains all the elements listed in a-f in this section. Anthem performs quarterly audits to make sure that this is being followed.</p>		
<p><b>HSAG Findings:</b> The Health Care Management Denial – Core Process policy and procedure contained the required components of an ABD notice and, overall, the ABD notices reviewed as part of the case file review included all required content. However, per the case file review results, one denial did not result in an ABD notice being sent to a member (case #3).</p> <p><b>Recommendations:</b> HSAG strongly recommends that the MCO update the ABD notice template and the enclosures to ensure accurate time frames related to the appeal process are documented appropriately. The MCO should also remove the language within the notices that require a written, signed appeal as this process is no longer required by federal rule. Implementation of these recommendations will be further assessed during future compliance reviews.</p>		
<p><b>Required Actions:</b> None.</p>		
Timing of Notice of Adverse Benefit Determination		
<p>7. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail the notice at least ten (10) days before the date of action. Additionally, the MCO must mail the notice no later than the date of the action when:</p> <p>a. The MCO has factual information confirming the death of a member;</p> <p>b. The MCO receives a clear written statement signed by a member that:</p> <p style="padding-left: 20px;">i. No longer wishes services; or</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• ABD template(s)</li> <li>• Tracking and reporting mechanism(s)</li> <li>• HSAG will also use the results of the service authorization denial file review.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 07. PP Health Care Management Denial – Core Process pgs. 12-14, 39</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>ii. Gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information;</p> <p>c. The member has been admitted to an institution where the member is ineligible under the plan for further services;</p> <p>d. The member’s whereabouts are unknown, and the post office returns agency mail directed the member indicating no forwarding address;</p> <p>e. The MCO establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;</p> <p>f. A change in the level of medical care is prescribed by the member’s physician;</p> <p>g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or</p> <p>h. The date of action will occur in less than ten (10) days, in accordance with 42 CFR §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30-day notice requirements of 42 CFR §483.15(b)(4)(i) of this chapter.</p> <p style="text-align: right;">42 CFR §431.211 42 CFR §431.213 42 CFR §438.404(c)(1) Contract 3.13.4.4-5</p>	<ul style="list-style-type: none"> <li>• 07. ANV-MEM-0406-18 NV QM Initial Denial Ltr Upd FINAL.docx</li> <li>• 07. NVUM0004 NV Facility Provider Admin Denial Letter.doc</li> <li>• 07. NVUM0016 NV Provider Admin Denial Letter.doc</li> <li>• 07 Provider Manual pgs. 44-45</li> <li>• 07. Member Handbook pg. 61</li> </ul>	
<p><b>MCO Description of Process:</b> If Anthem must terminate, suspend, or reduce previously authorized services, Anthem will send a notice to the member and provider stating such no less than 10 days prior to the termination, suspension or reduction of those services. Anthem performs quarterly audits to make sure that this is being followed.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p><b>Recommendations:</b> Although MCO staff members could verbalize the requirements related to this element, they also confirmed that they do not terminate, reduce, or suspend services. HSAG strongly recommends the MCO evaluate its procedures related to the termination, reduction, and suspension of previously authorized services and consider whether it would be appropriate in some instances to terminate, reduce, or suspend those services based on whether the services are still medically necessary (e.g., LTSS), and for those instances that are noted through the exceptions to the 10-day advance notice (e.g., death, moving out of service area, etc.). Further, HSAG recommends that the MCO conduct departmental training to ensure staff members understand what would constitute a termination, suspension, or reduction of services and determine whether there needs to be a system enhancement to track these types of adverse benefit determinations. Finally, HSAG recommends that the MCO develop a template ABD notice that would be readily available to send when there is a termination, suspension, or reduction in services. Implementation of these recommendations will be further assessed during future compliance reviews.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>8. The MCO may shorten the period of advance notice to five (5) days before the date of action if:</p> <p style="margin-left: 20px;">a. The MCO has facts indicating that action should be taken because of probable fraud by the member; and</p> <p style="margin-left: 20px;">b. The facts have been verified, if possible, through secondary sources.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §431.214 42 CFR §438.404(e)(1) Contract 3.13.4.4</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• ABD template(s)</li> <li>• Tracking and reporting mechanism(s)</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 08. PP Health Care Management Denial – Core Process pgs. 14-15, 39</li> <li>• 08. ANV-MEM-0713-19 NV Member Denial Letter Due to TAT ENG FINAL.DOCX</li> <li>• 08. ANV-MEM-0406-18 NV QM Initial Denial Ltr Upd FINAL.docx</li> <li>• 08. LTR NVUM0016 Provider Admin denial in MACCESS</li> <li>• 08. NVUM0004 NV Facility Provider Admin Denial Letter.doc</li> <li>• 08. Provider Manual pgs. 44-45</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VII— Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p><b>MCO Description of Process:</b> 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. Anthem performs quarterly audits to make sure that this is being followed.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>9. For the denial of payment, the MCO must mail the notice at the time of any action affecting the claim.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.404(c)(2) Contract 3.13.4.6</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>ABD template(s)</li> <li>Tracking and reporting mechanism(s)</li> <li>Workflow for payment denial on a claim to trigger an ABD notice</li> <li>One case example of an ABD notice sent to a member for the denial of payment on a claim</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>9. PP Health Care Management Denial - Core Process: page 14, 39</li> <li>9. NV Medicaid EOB Template</li> <li>9. CPEC EOB Process_NV</li> <li>9. EOB Case Example</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Anthem’s explanation of benefits (EOB) serves as its notice to members of claim payment actions. As soon as claims are finalized, the EOB process scans claims for EOB creation for claims that meet the criteria for sending EOBs.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Recommendations:</b> The MCO’s Health Care Management Denial – Core Process policy inaccurately indicated that the MCO must send the notice at least 10 days before the proposed action for the denial of payment. Although referenced as a National Committee for Quality Assurance (NCQA) requirement,</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>this policy also indicated that if the denial is post-service and the member is not at financial risk, the MCO is not required to notify the member. This statement conflicts with federal regulations. However, under the Nevada section of the policy, it appropriately indicated that the MCO must give notice by the date of action for several circumstances, including when the action is a denial of payment. As indicated in element 1, HSAG recommends that this policy be updated to ensure clarity and accuracy. Additionally, although the ABD notice for the denial of payment met the intent of the requirement, HSAG recommends that the MCO review the language regarding the member not having financial liability as there could be potential instances when the member may be liable for payment (e.g., goes to an out-of-network and non-Medicaid provider for services).</p>		
<b>Required Actions:</b> None.		
<p>10. For service authorization decisions not reached within the applicable time frame for standard or expedited requests (which constitutes a denial and is thus an ABD), the MCO must provide notice on the date that the time frames expire.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.404(c)(5) Contract 3.13.4.7</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>ABD template(s)</li> <li>Tracking and reporting mechanism(s)</li> <li>One case example of an ABD notice sent to a member due to the MCO’s failure to make a timely service authorization decision</li> <li>HSAG will also use the results of the service authorization denial file review.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>10. PP Health Care Management Denial – Core Process pgs. 14, 38</li> <li>10. ANV-MEM-0713-19 NV Member Denial Letter Due to TAT ENG FINAL.DOCX</li> <li>10. Sample 1-UM Missed TAT</li> <li>10. TAT Compliance</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCO Description of Process:</b> Turnaround time starts when the request is received at Anthem. Anthem follows the turnaround times laid out by the state of NV in accordance with state and federal regulations. If at which time Anthem is aware that they will not meet the set forth turnaround times, Anthem will</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
issue a denial and send the member and provider notification of that denial, as well as, letting them know that a medical necessity review will be performed at a later date. Anthem performs quarterly audits to make sure that this is being followed.		
<b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.		
<b>Required Actions:</b> None.		
Standard Authorization Decisions		
11. For standard authorization decisions, the MCO must provide notice as expeditiously as the member’s condition requires and within DHCFP-established time frames that may not exceed 14 calendar days following receipt of the request for service.  42 CFR §438.210(d)(1)(i-ii) Contract 3.13.3.1	<b>HSAG Recommended Evidence:</b> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Tracking and reporting mechanisms</li> <li>• Service authorization log</li> <li>• HSAG will also use the results of the service authorization denial file review.</li> </ul> <b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>• 11. PP Clinical Information for UM Reviews - Core Process pg. 17</li> <li>• 11. PP Health Care Management Denial – Core Process pg. 17</li> <li>• 11. Provider Manual pg. 44 (footer page #)</li> <li>• 11. UM 5.D TAT_NV</li> <li>• 11. TAT Compliance</li> <li>• 11. NV Data 11.2020 - 5.2021 Svc Log</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b> Turnaround time starts when the request is received at Anthem. Anthem follows the turnaround times laid out by the state of NV in accordance with state and federal regulations. Turnaround time reports are monitored on a continuous basis to make sure Anthem is compliant.		
<b>HSAG Findings:</b> Per the case file review, two cases (#3 and #4) were not determined within the required 14-day time frame.		
<b>Required Actions:</b> For standard authorization decisions, the MCO must provide notice as expeditiously as the member’s condition requires and within DHCFP-established time frames that may not exceed 14 calendar days following receipt of the request for service.		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>Expedited Authorization Decisions</b>		
<p>12. For cases in which a provider indicates, or the MCO determines, that following the standard time frame could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later than seventy-two (72) hours after receipt of the request for service.</p> <p style="text-align: right;">42 CFR §438.210(d)(2)(i-ii) Contract 3.13.3.2</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking and reporting mechanisms</li> <li>HSAG will also use the results of the service authorization denial file review.</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>12. PP Health Care Management Denial – Core Process pg. 38</li> <li>12. TAT Compliance</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Turnaround time starts when the request is received at Anthem. Anthem follows the turnaround times laid out by the state of NV in accordance with state and federal regulations. If it is deemed that the standard timeframe would jeopardize the members health, then the request is handled as an expedited request and decided within 72 hours. Turnaround time reports are monitored on a continuous basis to make sure Anthem is compliant.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>Extension of Time Frames</b>		
<p>13. The MCO may extend the review of a standard or expedited service authorization time frame up to 14 additional calendar days if—</p> <p>a. The member, or the provider, requests extension; or</p> <p>b. The MCO justifies (to DHCFP upon request) a need for additional information and how the extension is in the member’s interest.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.404(c)(4)(i-ii) Contract 3.13.5.3(b)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Extension notice template(s)</li> <li>One redacted copy of an extension notice and the corresponding benefit determination notice</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>13. PP Health Care Management Denial – Core Process pg. 18, 38</li> <li>13. LTR NVUM0022 NVUM QM Extension Letter</li> <li>13. TAT Compliance</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Turnaround time starts when the request is received at Anthem. Anthem follows the turnaround times laid out by the state of NV in accordance with state and federal regulations. If it is in the best interest of the member to extend the timeframe of the decision or the provider or member requests an extension; a letter will be mailed to the member and provider stating the reason for the extension and their right to file a grievance if they disagree with that decision.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>14. If the MCO meets the criteria set forth for extending the time frame for standard or expedited service authorization decisions, it must:</p> <p>a. Give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision; and</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Extension notice template(s)</li> <li>One redacted copy of an extension notice and the corresponding benefit determination notice</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA





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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>b. Issue and carry out its determination as expeditiously as the member’s health condition requires and no later than the date the extension expires.</p> <p style="text-align: right;">42 CFR §438.404(c)(4)(i-ii) Contract 3.13.5.3(b)</p>	<p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• 14. PP Health Care Management Denial – Core Process pgs. 14, 39</li> <li>• 14. PP Pre-Certification of Requested Services - Core Process pgs 33, 6-7</li> <li>• 14. LTR NVUM0022 NVUM QM Extension Letter</li> <li>• 14. TAT Compliance</li> </ul>	
<p><b>MCO Description of Process:</b> Turnaround time starts when the request is received at Anthem. Anthem follows the turnaround times laid out by the state of NV in accordance with state and federal regulations. If it is in the best interest of the member to extend the timeframe of the decision or the provider or member requests an extension; a letter will be mailed to the member and provider stating the reason for the extension and their right to file a grievance if they disagree with that decision. Note that Anthem did not have to use the extension letter during the review period and thus do not have an example copy of an extension notice to provide.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p> <p><b>Recommendations:</b> Although MCO staff members confirmed that they would take an extension if they did not have the information necessary to make a determination and had an appropriate template letter available during the time period under review, multiple cases were not resolved timely. Although HSAG does not know if untimely resolution was related to a staff resource constraint or whether the MCO was not appropriately tracking extension time frames, HSAG strongly recommends reviewing whether there is a process issue that is resulting in staff members not monitoring extended time frames appropriately. The MCO should also determine whether there is an opportunity to enhance its utilization management system to have those updated time frames populate systematically and alert staff members when the time frames are due. Further, although requested after the site visit, MCO staff members could not produce examples of extension letters sent during the time period under review, even though documentation appeared to indicate that three authorization time frames had been extended. Therefore, HSAG strongly recommends that the MCO re-train staff members to ensure the expectations associated with taking an extension, including the process for sending notification to the member timely, are clear. Implementation of these recommendations will be further assessed during future compliance reviews.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>Compensation for Utilization Management Activities</b>		
<p>15. The MCO must provide that, consistent with 42 CFR §§438.3(i), and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.210(e) Contract 3.10.19.3 (H)</p>	<p><b>HSAG Recommended Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>New hire and ongoing training for staff</li> <li>One example of a staff attestation</li> </ul> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>15. PP Prohibiting the Use of Financial Incentives When Making Medical Necessity Determinations – Core Process pg. 6</li> <li>15. Annual Training Certs pgs 22-23</li> <li>15. Incentives_Statement</li> <li>15. Do The Right Thing 2020 Report</li> <li>15. UM PH Team Learning Completion Status Report</li> <li>15. UM BH Team Learning Completion Status Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem ensures that the individuals who make decisions on denials are health care professionals who have the appropriate clinical expertise, as determined by the state, in treating the member’s condition or disease. The denial of services is based on a medical necessity review using clinically developed criteria. There are no financial incentives for approving or denying of services.</p> <p>One of Anthem’s annual associate “Do The Right Thing” required training modules includes a section with required annual certifications (enclosed). This includes a requirement to review and agree to the Incentives Statement (enclosed). Anthem’s “Do The Right Thing” training is tracked and reported at an enterprise level (Anthem, Inc.) for associates companywide. Enclosed is a list of all associates that completed the 2020 training.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCO has met the requirements for this element.</p>		
<p><b>Required Actions:</b> None.</p>		



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Standard VII—Coverage and Authorization of Services						
Met	=	13	X	1	=	13
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	15	Total Score		=	13
Total Score ÷ Total Applicable					=	87%

## Appendix B. Corrective Action Plan

Following this page is a document HSAG developed for **Anthem** to use in preparing its CAP. For each of the requirements listed as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the MCE will measure the effectiveness of the intervention.
- Individual(s) responsible for ensuring that the planned interventions are completed.
- Proposed timeline for completing each planned intervention.
- Evidence of compliance. This could include proposed revisions to policies and procedures, report templates, or other documentation, as needed.

This plan is due to DHCFP and HSAG no later than 30 calendar days following receipt of this final *State Fiscal Year 2021 Compliance Review* report.



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**SFY 2020–21 Compliance With Standards Review Tool CAP Template**

Standard II—Member Rights and Member Information			
Reference	Requirement	Information Submitted as Evidence by the MCO <sup>B-1</sup>	Score
Information for All Members With MCO—Member Handbook			
42 CFR §438.10(g)(2) Contract 3.6.1.1	15. The content of the member handbook must include information that enables the member to understand how to effectively use the managed care program—Refer to the Member Handbook Checklist.	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>• NV Member Handbook: All</li> <li>• Web Site Links - <a href="https://mss.anthem.com/nevada-medicaid/nvnev_caid_memberhandbook_eng.pdf">https://mss.anthem.com/nevada-medicaid/nvnev_caid_memberhandbook_eng.pdf</a> and <a href="https://mss.anthem.com/nevada-medicaid/nvnev_caid_memberhandbook_spa.pdf">https://mss.anthem.com/nevada-medicaid/nvnev_caid_memberhandbook_spa.pdf</a></li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCO Description of Process:</b>			
<p><b>HSAG Findings:</b> The MCO demonstrated compliance with the elements of the member handbook checklist with the exception of one sub-element. The member handbook effective during the review period contained the incorrect time frame of 90 calendar days from receipt of the adverse benefit determination for a member to file an appeal, instead of the required 60 calendar days. This issue was also identified during the last compliance review (the handbook included incorrect time frames for filing of member appeals and State fair hearing requests). The MCO staff members provided follow-up documentation after the interview session that indicated the member handbook was updated to include the 60-calendar day appeal time frame in June 2021; however, this was outside of the review period for this compliance review.</p> <p><b>Recommendations:</b> HSAG recommends that the MCO consider updating terminology from “Notice of Action” to “Adverse Benefit Determination” to fully align with federal rule terminology.</p>			
<p><b>Required Actions:</b> The MCO must ensure that the member handbook contains the correct time frame for member appeals.</p>			

<sup>B-1</sup> 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.



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Standard II—Member Rights and Member Information			
Reference	Requirement	Information Submitted as Evidence by the MCO <sup>B-1</sup>	Score
<b>Corrective Action Plan</b> (Include required action, responsible individual, and completion date.)			
<b>DHCFP Feedback</b> (To be completed by DHCFP/HSAG.)			<input type="checkbox"/> Accepted <input type="checkbox"/> Accepted With Recommendations <input type="checkbox"/> Not Accepted



**Appendix B. Corrective Action Plan**  
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Standard VI—Coordination and Continuity of Care			
Reference	Requirement	Information Submitted as Evidence by the MCO	Score
<b>Health Needs Assessment Screening</b>			
42 CFR §438.208(b)(3) Contract 3.10.20.2(B)(1)(a-b)	<p>5. The MCO must make a best effort to conduct an initial screening of each member’s needs within ninety (90) days of the effective date of enrollment for all new members.</p> <p>a. <i>Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within thirty (30) days;</i></p> <p>b. <i>The MCO must document at least three (3) attempts to conduct the screen. If unsuccessful the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first one hundred and twenty (120) days.</i></p> <p>c. <i>Face-to-face assessments shall be conducted, as necessary. The goals of the assessment are to identify the member’s existing and/or potential health care needs and assess the member’s need of case management services.</i></p> <p>d. <i>The MCO will submit their Health Needs Assessment Screening form/s and data to the DHCFP upon request.</i></p>	<p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• VI.5_PP_Case_Manager_Assessment: page 8</li> <li>• VI.5_PP_Identification_and_Monitoring_for_Special_Health_Care_Needs: page 2</li> <li>• VI.5_PP_Case_Management_Program_Case_Identification: page 2</li> <li>• VI.5_NV_Pursuant_HNA_Questions</li> <li>• VI.5_NV_Pursuant_HNA_Additional_Questions</li> <li>• VI.5_OB_High_Risk_Screener</li> <li>• VI.5_Pursuant_HNA_Tracking_Report_May_2021</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCO Description of Process:</b> Anthem has policies that establish the principles for delivery and implementation of health risk screening tool(s) for Case Management. Screenings and/or assessments are available both telephonically and in-person, as necessary. Within 30 days of Enrollment, a welcome call is placed to all members that provide a phone number. An assessment</p>			



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Standard VI—Coordination and Continuity of Care			
Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	is done of knowledge of benefits and of current needs. If clinical need is identified, then member is triaged for the appropriate program.		
	<p><b>HSAG Findings:</b> The case file review confirmed that the MCO did not consistently conduct three attempts to complete the initial health risk screening. MCO staff members explained that they internally identified opportunities for improving this process and are working with their vendor to remediate the identified gaps.</p> <p><b>Recommendations:</b> HSAG recommends that the MCO consult with DHCFP regarding the 834-enrollment file and if it includes indicators for members who are identified as pregnant or having a special health care need.</p> <p><b>Required Actions:</b> The MCO must make a best effort to conduct an initial screening of each member’s needs within 90 days of the effective date of enrollment for all new members. Screening assessment for pregnant women, children with special health care needs, and adults with special health care needs must be conducted within 30 days. The MCO must document at least three attempts to conduct the screening. If unsuccessful, the MCO must document the barrier(s) to completion and how the barriers shall be overcome so that the Health Needs Assessment can be accomplished within the first 120 days.</p>		
<b>Corrective Action Plan</b> (Include required action, responsible individual, and completion date.)			
<b>DHCFP Feedback</b> (To be completed by DHCFP/HSAG.)			<input type="checkbox"/> Accepted <input type="checkbox"/> Accepted With Recommendations <input type="checkbox"/> Not Accepted





**Appendix B. Corrective Action Plan**  
**Nevada Division of Health Care Finance and Policy**  
**State Fiscal Year 2021 MCE Compliance Review**  
**for Anthem Blue Cross and Blue Shield Healthcare Solutions**

Standard VII—Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the MCO	Score
<b>Notice of Adverse Benefit Determination</b>			
42 CFR §438.402(b-c). 42 CFR §438.404(b)(1-6) Contract 3.13.4.3	6. The MCO must notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member’s notice must meet the requirements of §438.404. The notice must explain the following: <ol style="list-style-type: none"> <li>a. The adverse benefit determination (ABD) the MCO has made or intends to make.</li> <li>b. The reasons for the ABD, including the right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s ABD. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits and <i>the specific regulations that support, or the change in federal or State law that requires the action.</i></li> <li>c. The member's right to request an appeal of the MCO’s ABD, including information on exhausting the MCO’s one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR §438.402(c).</li> </ol>	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>• 06. PP Health Care Management Denial - Core Process pgs 12-13, 39</li> <li>• 06. ANV-MEM-0406-18 NV QM Initial Denial Ltr Upd FINAL.docx</li> <li>• 06. ANV-MEM-0713-19 NV Member Denial Letter Due to TAT ENG FINAL.DOCX</li> <li>• 06 Appeal Rights and Continuation Attachments</li> <li>• 06. NVUM0016 NV Provider Admin Denial Letter.doc</li> <li>• 06. LTR NVUM0016 Provider Admin Denial in MACCESS</li> <li>• 06. Provider Manual pgs. 44-48 (footer page #s)</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
	d. The procedures for exercising the rights specified in 42 CFR §438.404(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member’s right to have benefits continue pending resolution of the appeal; how to request that benefits be continued; and the circumstances, consistent with DHCFP policy, under which the member may be required to pay the costs of these services.		
	<b>MCO Description of Process:</b> Anthem sends out notice of action to members and providers for any full or partial denial of services. The notice of action contains all the elements listed in a-f in this section. Anthem performs quarterly audits to make sure that this is being followed.		
	<b>HSAG Findings:</b> The Health Care Management Denial – Core Process policy and procedure contained the required components of an ABD notice and, overall, the ABD notices reviewed as part of the case file review included all required content. However, per the case file review results, one denial did not result in an ABD notice being sent to a member (case #3). <b>Recommendations:</b> HSAG strongly recommends that the MCO update the ABD notice template and the enclosures to ensure accurate time frames related to the appeal process are documented appropriately. The MCO should also remove the language within the notices that require a written, signed appeal as this process is no longer required by federal rule. Implementation of these recommendations will be further assessed during future compliance reviews.		
	<b>Required Actions:</b> None.		
<b>Corrective Action Plan</b> (Include required action, responsible individual, and completion date.)			



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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
DHCFP Feedback (To be completed by DHCFP/HSAG.)			<input type="checkbox"/> Accepted <input type="checkbox"/> Accepted With Recommendations <input type="checkbox"/> Not Accepted



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Standard VII—Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the MCO	Score
<b>Standard Authorization Decisions</b>			
42 CFR §438.210(d)(1)(i-ii) Contract 3.13.3.1	11. For standard authorization decisions, the MCO must provide notice as expeditiously as the member’s condition requires and within DHCFP-established time frames that may not exceed 14 calendar days following receipt of the request for service.	<b>Evidence as Submitted by the MCO:</b> <ul style="list-style-type: none"> <li>• 11. PP Clinical Information for UM Reviews - Core Process pg. 17</li> <li>• 11. PP Health Care Management Denial – Core Process pg. 17</li> <li>• 11. Provider Manual pg. 44 (footer page #)</li> <li>• 11. UM 5.D TAT_NV</li> <li>• 11. TAT Compliance</li> <li>• 11. NV Data 11.2020 - 5.2021 Svc Log</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
	<b>MCO Description of Process:</b> Turnaround time starts when the request is received at Anthem. Anthem follows the turnaround times laid out by the state of NV in accordance with state and federal regulations. Turnaround time reports are monitored on a continuous basis to make sure Anthem is compliant.		
	<b>HSAG Findings:</b> Per the case file review, two cases (#3 and #4) were not determined within the required 14-day time frame.		
	<b>Required Actions:</b> For standard authorization decisions, the MCO must provide notice as expeditiously as the member’s condition requires and within DHCFP-established time frames that may not exceed 14 calendar days following receipt of the request for service.		
<b>Corrective Action Plan</b> (Include required action, responsible individual, and completion date.)			



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Reference	Requirement	Information Submitted as Evidence by the MCO	Score
<b>DHCFP Feedback</b> (To be completed by DHCFP/HSAG.)			<input type="checkbox"/> Accepted <input type="checkbox"/> Accepted With Recommendations <input type="checkbox"/> Not Accepted