Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

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

for

SilverSummit Healthplan, Inc.

June 2018

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

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

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

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

SilverSummit had a composite score of 99.8 percent for all elements evaluated in the SFY 2017–2018 IQAP Compliance Review. With a couple of exceptions noted in this report, **SilverSummit** demonstrated strong compliance with the federal and State requirements contained in its managed care contract. Table 1-1 summarizes the overall ratings for **SilverSummit**'s IQAP standards, checklists, and file reviews for the SFY 2017–2018 IQAP Compliance Review.

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

Overall Ratings for SilverSummit	
IQAP Standards Score	For the IQAP Standards, **SilverSummit** received a total score of **99.2%**.
Checklist Score	For the Checklist review, **SilverSummit** received a total score of **100%**.
File Review Score	For the File Review, **SilverSummit** received a total score of **100%**.
Composite Score	**SilverSummit** received an overall rating of **99.8%** for all elements reviewed

2. Background

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

Mandatory Activity

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

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

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

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

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

Purpose of the Review

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

3. Methodology

Compliance Review Process

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

Methods for Data Collection

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

Pre-on-site review activities included:

- Developing the compliance review tools.
- Providing to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents that each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample cases plus an oversample of five cases for the credentialing file review.
- Reviewing delegated subcontractors' contracts.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Mar 9, 2018.

On-site review activities included:

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

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

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

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers and subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included but were not limited to: utilization management, quality management, care management and coordination, health

management and service authorization, credentialing, cultural competency, delegation and contracting, and member education.

- MCO-maintained files for practitioner credentialing and recredentialing.
- MCO questionnaire.

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

IQAP Standards, Checklists, and Files Reviewed

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

Table 3-1—IQAP Standards

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

Table 3-2—Provider Manual Checklist

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

Table 3-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
I	Initial Credentialing	159
I	Recredentialing	N/A*
III	Delegated Subcontracts	24
	Total Number of File Review Elements	**183**

* Recredentialing occurs every three years after initial credentialing. SilverSummit entered the Nevada market July 1, 2017; therefore, it had not been an MCO long enough for recredentialing to be applicable.

Data Aggregation and Analysis

IQAP Standards

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

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

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

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

Provider Manual Checklist

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

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

File Reviews

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

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

Aggregating the Scores

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

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

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

Evaluation Ratings for SilverSummit

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

IQAP Standards

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

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

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Credentialing and Recredentialing	15	15	15	0	0	0	100%
II	Availability and Accessibility of Services	26	26	25	1	0	0	98.1%
III	Subcontracts and Delegation	13	13	13	0	0	0	100%
IV	Provider Dispute and Complaint Resolution	7	7	7	0	0	0	100%
V	Provider Information	3	3	3	0	0	0	100%
Total Compliance Score		**64**	**64**	**63**	**1**	**0**	**0**	**99.2%**

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

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

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

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

A review of the IQAP standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. Of the 64 applicable elements, **SilverSummit** received *Met* scores for 63 elements, *Partially Met* scores for one element, and *Not Met* scores for no elements. The findings suggest that **SilverSummit** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate compliance with the contract. Further, interviews with **SilverSummit** staff showed that staff members were knowledgeable about the

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

The areas with the greatest opportunity for improvement for IQAP standards related to availability and accessibility of services and using Geo Access Reports to monitor the network, identify gaps in the network, and make the necessary adjustments needed to fill gaps in the network for specialty providers. Although **SilverSummit** staff members stated that they identified gaps in the network and were working to address those gaps, the Geo Access Reports still showed deficiencies in meeting the network availability requirements outlined in the contract. **SilverSummit** should monitor its network on a regular basis including the use of GeoAccess mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.

Provider Manual Checklist Review

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

Table 4-2—Checklist Score

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

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

File Reviews

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

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

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
I	Initial Credentialing	10	159	159	100%
I	Recredentialing*	N/A	N/A	N/A	N/A
III	Delegated Subcontractor	5	24	24	100%
	File Review Totals	**15**	**183**	**183**	**100%**

* Recredentialing occurs every three years after initial credentialing. SilverSummit entered the Nevada market July 1, 2017; therefore, it had not been an MCO long enough for recredentialing to be applicable.

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Of the 183 total elements reviewed for the file reviews, **SilverSummit** received *Met* scores for 183 elements. All the areas reviewed scored 100 percent. These results suggest that **SilverSummit** developed contractually compliant policies and procedures and that the MCO followed the policies it developed to operationalize the required elements of its contract.

Conclusions and Recommendations

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

Table 5-1—Overall Rating for SilverSummit

IQAP Standards Score	For the IQAP Standards, **SilverSummit** received a total score of **99.2%**.
Checklist Score	For the Checklist review, **SilverSummit** received a total score of **100%**.
File Review Score	For the File Review, **SilverSummit** received a total score of **100%**.
Composite Score	**SilverSummit** received an overall rating of **99.8%** for all elements reviewed in the SFY 2017–2018 IQAP Compliance Review.

SilverSummit's overall result for the review of the IQAP standards in the SFY 2017–2018 IQAP Compliance Review was 99.2 percent. In addition, **SilverSummit** received a score of 100 percent for the file review, a score of 100 percent for the checklist review, and an overall composite score of 99.8 percent. The overall results demonstrated that **SilverSummit** had strong adherence to State and federal standards required by its contract with the DHCFP. **SilverSummit** developed the necessary policies, procedures, and plans to carry out the required functions of the contract; and the checklist and file review results demonstrated that **SilverSummit** staff appropriately operationalized the elements described in **SilverSummit**'s policies, procedures, and plans.

Compliance With IQAP Standards

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

The *Availability and Accessibility of Services* standard achieved 98.1 percent for all elements contained in the standard.

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

Compliance With Checklists

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

Compliance With File Review

SilverSummit achieved 100 percent compliance on the initial credentialing file review, which indicates the MCO's strong compliance with the credentialing file review standards.

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

Corrective Action Plan

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

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

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

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

Appendix A. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
State Fiscal Year 2017–2018 Internal Quality Assurance Program
Compliance Review Tool
for SilverSummit Healthplan, Inc.

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.214(a-b) *DHCFP Contract Section 3.16.2.1 (A)*	1. Provider Credentialing The MCO must have written credentialing and recredentialing policies and procedures for determining and assuring that all providers under contract to the MCO, including PCPs and Primary Care Specialists (PCSs), specialists, and other health care professionals, are licensed by the State and qualified to perform the services.	**Documents Submitted:** • CC.CRED.01– Practitioner Credentialing and Recredentailing and Attachment Q - Nevada • Credentialing Requirement Grid **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Practitioner Credentialing and Recredentialing policy and procedure contained the written credentialing and recredentialing policies and procedures used by SilverSummit to ensure that physicians and other healthcare practitioners are licensed by the State and qualified to render services to their Nevada Medicaid members.		
	Recommendations: None.		
42 CFR §438.214(d) *DHCFP Contract Section 3.16.2.1 (A)*	2. Providers Excluded from Participation in Federal Health Care Programs The MCO may not employ or contract with providers excluded from participation in federal health care programs under section 1128 of the Social Security Act.	**Documents Submitted:** • CC.CRED.01 – Practitioner Credentialing and Recredentailing: section II Verification of Items Requiring Primary Source Verification, & Section IX Determination and Review of Clean Files, & section X Committee Review of Unclean Files • CC.CRED.06 • Sanction Monitoring Log 2017	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		Description of Process:	
	Findings: The Ongoing Monitoring of Sanctions and Complaints policy and procedure stipulated that SilverSummit could not employ or contract with providers excluded from participation in federal healthcare programs. During the interview session, SilverSummit staff members confirmed network and employed providers are reviewed for sanctions monthly.		
	Recommendations: None.		
42 CFR §438.12(a)(1) *42 CFR §438.214(c)* *DHCFP Contract Section 3.7.2.10*	3. Discrimination Against Providers The MCO: a) May not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license, specialty, or certification; and b) If the MCO declines to include an individual or groups of providers in its network, it must give the affected network provider(s) written notice of the reason for its decision.	**Documents Submitted:** • CC.CRED.04 & Attachment Q • CC.CRED.01 – Practitioner Credentialing and Recredentailing, section XI Denial of Initial Credentialing/Recredentialing Application **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Nondiscriminatory Credentialing and Recredentialing policy and procedure included Attachment Q, which contained the information concerning nondiscrimination of participation, reimbursement, or indemnification of providers acting within the scope of their licenses. The Practitioner Credentialing and Recredentialing policy and procedure maintained that practitioners denied participation in the network could request reconsideration within 30 calendar days of the date of the denial letter. During the on-site review, SilverSummit provided a copy of a written notification sent to a provider that included the denial reason.		
	Recommendations: None.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.16.2.1 (B)	4. Credentialing Criteria The MCO shall provide credentialing criteria for review and approval by DHCFP's Provider Enrollment unit ninety (90) calendar days prior to the start of the contract and ensure that all network providers meet the criteria.	**Documents Submitted:** • Email- Pre Go-Live email for Credentialing Policies sent for Approval **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: SilverSummit staff members furnished a copy of an email sent to the DHCFP on March 31, 2017, to validate that the credentialing policies and procedures were sent for approval within 90 calendar days prior to the start of the contract.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15	5. Credentialing Provisions in IQAP The IQAP must contain provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the MCO, are qualified to perform their services.	**Documents Submitted:** • NV.QI.01 IQAP Program Description–page 9-10; Credentialing Committee-section: committee composition • Credentialing Committee Meeting Minutes – Available for onsite review **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit Health Plan 2017–2018 Internal Quality Assurance Program (IQAP) Description identified the Credentialing Committee as the standing subcommittee of the Quality Improvement Committee (QIC) responsible for administering the daily oversight and acting as operating authority of the Credentialing Program. The program description noted that the Credentialing Committee had final authority for the review and approval of licensed providers, other licensed healthcare professionals, and facilities with independent relationships with SilverSummit. The program description further noted that the Peer Review Committee reviews suspected inappropriate or aberrant service by a provider and recommends corrective action when necessary.		
	Recommendations: None.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.214(b)(1) *DHCFP Contract Section 3.10.15.1*	6. Written Credentialing Policies and Procedures The MCO has written policies and procedures that include a uniform documented process for credentialing, which include the MCO's initial credentialing of practitioners, as well as its subsequent recredentialing, recertifying and/or reappointment of practitioners. The MCO complies with the Nevada Administrative Code (NAC) 679B.0405 which requires the use of Form Nevada Department of Insurance (NDOI)-901 for use in credentialing providers.	**Documents Submitted:** CC.CRED.01– Practitioner Credentialing and Recredentailing CC.CRED.02 – Maintaining Confidentiality CC.CRED.03 – Credentialing Committee CC.CRED.04 – Nondiscrim Cred and Recred CC.CRED.05 – Practitioner Office Site Review CC.CRED.06 – Ongoing Monitoring of Sanctions & Compliants CC.CRED.07 – Pract Disciplinary Actions and Reporting CC.CRED.08 – Practitioner Appeal Hearing Process CC.CRED.09 – Organizational Assessment CC.CRED.10 – Prof Competence and Board Cert CC.CRED.11 – Quality Review Process CC.CRED.12 – Oversight of Delegated Credentialing **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Practitioner Credentialing and Recredentialing policy and procedure demonstrated the MCO's processes for credentialing, recredentialing, and ongoing monitoring of practitioners. Attachment Q of the Practitioner Credentialing and Recredentialing policy and procedure contained the requirement to use the NDOI-901 form when credentialing providers in the State of Nevada.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.2	7. Credentialing Oversight The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	**Documents Submitted:** • CC.CRED.03- Credentialing Committee, Section III Responsibilities (page 4, ii) • NV.QI.01 – IQAP Program Description, page 9-10 • Credentialing Oversight -Committee PPs – Minutes available for onsite review **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The IQAP Program Description noted that the board of directors delegated the operating authority of the IQAP to the Quality Improvement Committee. The Quality Improvement Committee's designated subcommittees included the Credentialing Committee. The Credentialing Committee was responsible for administering the daily oversight and operating authority of the Credentialing Program, to include the development and annual review of the credentialing policies and procedures. The Credentialing Committee policy and procedure also contained the requirements of this element.		
	Recommendations: None.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.15.3	8. Credentialing Entity The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.	**Documents Submitted:** CC.CRED.01 – Practitioner Credentialing and Recredentailing CC.CRED.03 – Credentialing Committee **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The IQAP Program Description noted that the board of directors delegated the operating authority of the IQAP to the Quality Improvement Committee. The Quality Improvement Committee's designated subcommittees included the Credentialing Committee. The Credentialing Committee was responsible for administering the daily oversight and acting as operating authority of the Credentialing Program, to include review and approval of licensed providers and other licensed healthcare professionals. The Credentialing Committee policy and procedure also contained the requirements of this element. A review of Credentialing Committee meeting minutes during the on-site review further confirmed that the Credentialing Committee makes recommendations regarding credentialing decisions.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.4	9. Scope of Credentialing The MCO identifies those practitioners who fall under its scope of authority and action. This includes, at a minimum, all physicians and other licensed independent practitioners included in the MCO's literature for recipients.	**Documents Submitted:** CC.CRED.01 – Practitioner Credentialing and Recredentailing; page 2-3 and Attachment Q **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Practitioner Credentialing and Recredentialing policy and procedure identified the practitioners falling under the MCO's scope of authority and action. Attachment Q of this policy further defined the additional provider licensure types recognized as qualified mental health professionals.		
	Recommendations: None.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §1003.3 *DHCFP Contract Section 3.10.15.6 (D-E)*	10. Recredentialing: Reporting to the State The MCO's provider recredentialing must comply with 42 CFR §1003.3. If the MCO decredentials, terminates or disenrolls a provider the MCO must inform the State within 15 calendar days.	**Documents Submitted:** NV.PRVR.23 – Provider Termination Policy **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Provider Termination Policy noted that "for cause" terminations must adhere to requirements of the State and federal agencies. This policy further indicated that the DHCFP would be notified within five business days when a provider has been terminated, decredentialed, or disenrolled. During the on-site review, the MCO provided a termination report demonstrating the State was notified of the termination.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.6 (E)	11. Recredentialing: Decredentialing, Terminating, or Disenrolling Providers If the decredentialing, termination, or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse the DHCFP notifies Health and Human Services-Office of the Inspector General (HHS-OIG).	**Documents Submitted:** NV.PRVR.23 – Provider Termination Policy – page 2, #5 CC.CRED.07- Pract Disciplinary Actions and Reporting **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Provider Termination Policy noted that "for cause" termination processes must comply with the requirements of State and federal agencies. This policy also specified that the DHCFP would be notified within five business days when a provider has been terminated, decredentialed, or disenrolled.		
	Recommendations: None.		

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.15.7	12. Delegation of Credentialing Activities If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities: a) There must be a written description of the delegated activities, and the delegate's accountability for these activities; b) There must also be evidence that the delegate accomplished the credentialing activities; and c) The MCO must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.	**Documents Submitted:** CC.CRED.12 – Oversight of Delegated Credentialing Delegated Credentialing Agreement Template **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Oversight of Delegated Credentialing policy delineated the delegate's and the MCO's responsibilities, including the information contained within the written delegation agreement. This policy further described the MCO's monitoring process and the activities that occur through delegate oversight meetings and the annual evaluation. The Delegated Credentialing Agreement template also supported components of this element. During the on-site review, the MCO provided an executed written agreement for Renown Health, which included the delegate's responsibilities to perform credentialing and recredentialing activities on behalf of the MCO. This contract also described the quarterly reporting requirements, which are used to monitor the delegate. Additionally, documentation supported that the MCO conducted a pre-delegation audit of credentialing activities for this delegate in March 2017. Credentialing Committee minutes demonstrated that the committee reviewed the results of pre-delegation, annual assessments, and evaluation of each delegate's compliance with regular reports.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.8	13. Retention of Credentialing Authority The MCO retains the right to approve new practitioners and sites, and to terminate or suspend individual practitioners. The MCO has policies and procedures for	**Documents Submitted:** CC.CRED.01 – Practitioner Credentialing and Recredentialing; Attachment Q CC.CRED.03 – Credentialing Committee	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	the suspension, reduction, or termination of practitioner privileges.	**Description of Process:**	
	Findings: Attachment Q of the Practitioner Credentialing and Recredentialing policy and procedure included the statement that SilverSummit retained the right to approve new practitioners and sites. The Practitioner Credentialing and Recredentialing policy and procedure included the process to suspend or terminate practitioner privileges. The policy also noted that the Credentialing Committee could determine that corrective action may be necessary to credential a practitioner and that the committee would define the steps the practitioner must take to fulfill the compliance requirements.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.9	14. Reporting to Appropriate Authorities The MCO must ensure there is a mechanism for, and evidence of, implementation of the reporting of serious quality deficiencies resulting in suspension or termination of a practitioner, to the appropriate authorities.	**Documents Submitted:** CC.CRED.06 – Ongoing Monitoring of Sanctions & Complaints, Procedure I, section F, subsection iii CC.CRED.07 - Pract Disciplinary Actions and Reporting; Policy section **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Practitioner Disciplinary Action and Reporting policy and procedure included the process used to report to the appropriate authorities, serious quality deficiencies resulting in suspensions or terminations.		
	Recommendations: None.		
DHCFP Contract Section 3.10.15.10	15. Provider Dispute Process The MCO must have a provider appeal process for instances wherein the MCO chooses to deny, reduce, suspend, or terminate a practitioner's privileges with the MCO.	**Documents Submitted:** CC.CRED.08 – Practitioner Appeal Hearing Process Provider Denial – Initial Credentialing **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard I: Credentialing and Recredentialing			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Practitioner Disciplinary Action and Reporting policy and procedure and the Practitioner Appeal Hearing Process policy and procedure included information regarding the practitioner's appeal process, which was consistent with this element.		
	Recommendations: None.		

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

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.206(b)(1) *42 CFR §438.207(b)(2)* *42 CFR §438.208(b)(2-4)* *DHCFP Contract Section 3.4.2.7*	1. Network of Providers The MCO must maintain and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all eligible recipients enrolled in the MCO's managed care program.	**Documents Submitted:** NV.CONT.01-Network Adequacy Selection Maintenance and Retention, pg.1 under Policy Geo Access Report https://providersearch.silversummithealthplan.com/ **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.CONT.01-Network Adequacy Selection, Maintenance, and Retention, contained the requirement for SilverSummit to maintain and monitor a network of appropriate providers sufficient to ensure access to all services offered in Nevada's Medicaid managed care program. The Participating Provider Agreement contract template demonstrated that the MCO executed written agreements with network providers. SilverSummit's website included a search agent for members to search for providers using an address, county, or ZIP code. The Geo Access Report also provided evidence that SilverSummit monitored geographic access standards for primary care and specialty providers contracted with the MCO.		
	Recommendations: None.		
42 CFR §438.207(b)(1-2) *DHCFP Contract Section 3.4.2.7 (A-E)*	2. Establishing and Maintaining a Network of Providers In establishing and maintaining the network, the MCO must consider the following: a) The anticipated DHCFP recipient managed care enrollment; b) The numbers of network providers who currently are and are not accepting new Medicaid and Nevada Check Up recipients; c) The expected utilization of services, including a description of the utilization management software	**Documents Submitted:** NV.CONT.01-Network Adequacy Selection Maintenance and Retention Geo Access Report **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	or other process used by the plan, taking into consideration the characteristics and health care needs of specific Medicaid and Nevada Check Up populations; d) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid covered services; and e) The geographic location of providers and enrolled recipients, considering distance (pursuant to NAC 695C.160), travel time, the means of transportation ordinarily used by recipients, and whether the location provides physical access for recipients with disabilities.		
	Findings: The policy, NV.CONT.01-Network Adequacy Selection, Maintenance, and Retention, described SilverSummit's considerations while establishing and maintaining the network, which included all the elements noted in this standard. The Geo Access Report provided evidence that SilverSummit monitored geographic access standards for primary care and specialty providers contracted with the MCO. The Geo Access Report highlighted several deficiencies wherein members were without access to the following specialties and locations: behavior technicians in Reno, gastroenterology in Reno, and vascular surgery in Reno as well as in Clark County. SilverSummit staff members stated that they were aware of the deficiencies and made efforts to secure contracts with additional providers to fill the gaps in the network. SilverSummit staff members stated that they reviewed the provider network every two weeks in conjunction with prior authorization requests to determine the additional providers and provider types necessary to assure access for members.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.207(c)(3)(i-ii) *DHCFP Contract Section 3.7.2.11*	3. Reporting Requirements The MCO must submit documentation to the State demonstrating the capacity to serve the expected enrollment when there has been a change in the MCO's services, benefits, geographic service area or payments, or enrollment of a new population in the network.	**Documents Submitted:** Network Adequacy Report Q3 Hospital Adequacy Report Q3 Network Adequacy Report Q4 Hospital Adequacy Report Q4 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The network adequacy reports for hospitals and other providers and the Geo Access Reports provided evidence that SilverSummit reports on the provider network. SilverSummit staff members stated that they submitted the quarterly reports to the DHCFP as required. The read receipts received by SilverSummit staff members from the DHCFP provided evidence that the reports were submitted to the DHCFP as required.		
	Recommendations: None.		
DHCFP Contract Section 3.4.2.8	4. Freedom of Choice of Providers The MCO must allow each recipient to choose his or her health care professional, including a PCP, to the extent possible and appropriate.	**Documents Submitted:** NV.ELIG.01 PCP Selection with a Closed Panel NV.ELIG.04 PCP Change Selection **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, CC.CM.01.04 New Member Welcome Calls, described the process for outreaching to new members and helping the member select a primary care provider (PCP). The document, 0417 NV New Member Welcome Call Script_v4, included the script that member services representatives referenced when working with Medicaid members. The script included step-by-step instructions for helping members select a PCP if they did not already have one. The SilverSummit member handbook also contained a chapter titled, "Choosing a Primary Care Provider (PCP)," that instructed members to select a PCP and how to contact SilverSummit to select a PCP.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		
42 CFR §438.206(b)(2) *DHCFP Contract Section 3.4.2.8 (E)*	5. Direct Access to Women's Health Specialists The MCO must provide female recipients with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the recipient's designated PCP, if that source is not a women's health specialist.	**Documents Submitted:** NV.UM.06.03-Women's Health Family Planning and Abortion Services SilverSummit Member Handbook, pg.30 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit member handbook included the requirements for this element and confirmed that members may select a women's health specialist in or out of the SilverSummit network. The Women's Health Family Planning and Abortion Services policy and procedure also confirmed the requirement of this element and indicated that the women's health specialist provider may be in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.		
	Recommendations: None.		
42 CFR §438.206(b)(3-4) *DHCFP Contract Section 3.4.2.10*	6. Second Opinions The MCO must provide for a second opinion from a qualified health care professional within the network, or arrange for the recipient to obtain one outside of the network, at no cost to the recipient.	**Documents Submitted:** NV.UM.01.01 Covered Benefits and Services, pg.5 III SilverSummit Member Handbook, pg.26 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit member handbook and the policy, NV.UM.01.01 Covered Benefits and Services, included the provision for second opinions within or outside the network at no cost to the recipient.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.206(b)(5) *DHCFP Contract Section 3.4.2.11*	7. Payment of Out-of-Network Providers The MCO must coordinate with out-of-network providers with respect to payment.	**Documents Submitted:** CC.UM.17 Single Case Agreement, Work Process: pg.1 Section 2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.UM.01.01 Covered Benefits and Services, included the provision that the MCO will coordinate with out-of-network providers regarding payment and communication with the member's PCP.		
	Recommendations: None.		
42 CFR §438.206(c)(1)(i-vi) *DHCFP Contract Section 3.4.2.13*	8. Hours of Operation The MCO must: a) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial recipients or comparable to Medicaid fee-for-service (FFS), if the provider services only Medicaid enrollees pursuant to 42 CFR §438.206. b) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services; c) Make services included in the RFP available twenty-four (24) hours per day, seven (7) days per week, when medically necessary; d) Establish mechanisms to ensure compliance by providers;	**Documents Submitted:** NV.PRVR.06 Evaluation for Timely Access to Care and Services SilverSummit Healthplan Provider Manual, pg.8-11 PPA Agreement pg.23 #13 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	e) Monitor providers regularly to ensure compliance and take corrective action if there is a failure to comply.		
	Findings: The policy, NV.PRVR.06 Evaluation for Timely Access to Care and Services, contained the requirements for this element. The policy noted that SilverSummit would disseminate Appointment Accessibility standards to providers via the provider manual. The SilverSummit provider manual provided evidence that the information was contained in the manual. The policy, NV.CONT.01 Network Adequacy Selection Maintenance and Retention, described SilverSummit's approach to evaluate the network to determine compliance with availability standards, including hours of operation, and the process to address deficiencies through corrective action. SilverSummit staff members who were part of the provider services unit described the site visits that staff members conducted at provider office locations. The form used to document the site visit included information related to appointment wait times. Staff members stated that each provider was visited at least annually, and they also completed follow-up visits for providers that had an issue or deficiency noted through a previous site visit, complaint received by a member, provider claims submission issues, or gaps in care that needed to be addressed. The completed site visit forms for providers, Medical Care Now, Mission Treatment Center, and Next Chapter Therapy provided evidence that provider relations staff completed site visits at provider site locations.		
	Recommendations: None.		
42 CFR §438.114(b)(1) *DHCFP Contract Section 3.4.2.14*	9. Emergency Coverage The MCO must provide emergency coverage twenty-four (24) hours per day, seven (7) days per week. The MCO must have written policies and procedures describing how recipients and providers can obtain emergency services after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff.	**Documents Submitted:** NV.UM.12 Emergency Services-No PLP Process NV.UM.01 Utilization Management Program Description, pg.28 SilverSummit Member Handbook, pg.27 NV.MSPS.21-Member and Provider Telephone Hotline, pg.3 #8 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Utilization Management Program Description, the Member and Provider Telephone Hotline policy and procedure, and the Emergency Services—No Prudent Layperson (PLP) Process policy and procedure included the requirements for this element. The SilverSummit member handbook contained, in multiple locations throughout the document, information concerning emergency services; and the provider manual noted the requirement for emergency care.		
	Recommendations: None.		
DHCFP Contract Section 3.4.2.14	10. Urgent Care The MCO must have written policies and procedures describing how recipients and providers can obtain urgent coverage after business hours and on weekends. Policies and procedures must include provision of direct contact with qualified clinical staff. Urgent coverage means those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received.	**Documents Submitted:** NV.UM.12 Emergency Services-No PLP Process NV.UM.01 utilization Management Program Description, pg.28 SilverSummit Member Handbook, pg.27 NV.MSPS.21-Member and Provider Telephone Hotline, pg.3 #8 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Utilization Management Program Description, the Member and Provider Telephone Hotline policy and procedure, and the Emergency Services—No PLP Process policy and procedure included the requirements for this element. The SilverSummit member handbook contained, in multiple locations throughout the document, information about urgent care services; and the provider manual specified that PCPs should provide same-day service to members with urgent care needs.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.9	11. Out-of-Network Providers Covering services with out-of-network providers: a) If the MCO's provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the MCO must adequately and timely cover these services out of network for the recipient for as long as the MCO is unable to provide them. b) The MCO benefit package includes covered medically necessary services for which the MCO must reimburse certain types of providers with whom formal contracts may not be in place. c) The MCO must also coordinate these services with other services in the MCO benefit package.	**Documents Submitted:** NV.UM.01 Utilization Management Program Description, pg.21-22 CC.UM.01.08 Use of Out of Network providers and Steerage CC.UM.17 Single Case Agreement Single Case Agreement Process for Contracting **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Utilization Management Program Description and the policy, CC.UM.01.08 Use of Out-of-Network Providers and Steerage, included the requirements of this element. The document, Single Case Agreement Process for Contracting, detailed the steps staff members would take to execute a single case agreement with the provider if he/she did not agree to join the SilverSummit network.		
	Recommendations: None.		
DHCFP Contract Section 3.6.3.2	12. Twenty-five (25) Mile Rule The MCO must offer every enrolled recipient a PCP or Primary Care Site located within a reasonable distance from the enrolled recipient's place of residence, but in any event, the PCP or PCS may not be more than twenty-five (25) miles from the enrolled recipient's place of residence	**Documents Submitted:** NV.CONT.01 Network Adequacy Selection Maintenance and Retention, pg.2 #2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	per NAC 695C.160 without the written request of the recipient.		
	Findings: The policy, NV.CONT.01 Network Adequacy Selection Maintenance and Retention, included the provisions for offering each member access to a PCP within 25 miles from the member's place of residence. The document, NV.QI.04 Evaluation of Practitioner Availability, included the provision that each member would have access to a PCP within 25 miles from the member's place of residence. The document also described the process for the MCO's monitoring of its network to these standards. The Geo Access Reports provided evidence that the MCO monitored its network to this standard.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.1–3.7.5.5	13. Access and Availability The MCO shall: a) Ensure adequate physical and geographic access to covered services for enrolled recipients; b) On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards; c) Partner actively with DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP recipients. d) Assure access to health screenings, reproductive services and immunizations through county and state public health clinics.	**Documents Submitted:** Geo Access Report EPSDT Log-Available On-Site EPSDT SOP PAC NV Agenda 4.23 CC.CM.01.04 New Member Welcome Calls 0417-NV New Member Welcome Call Scrip_v4 0617_New Member Orientation Script 2017 Welcome Call Report HRS Form **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	e) Promote care management and early intervention services by completing welcome calls and/or visits to new recipients to ensure orientation with emphasis on access to care, choice of PCP, and availability of an initial health risk screening occurs proactively with each recipient who becomes enrolled. If a screening risk level determines need for further care management, a care management referral will be completed.		
	Findings: The Geo Access Report provided evidence that SilverSummit monitored geographic access standards for primary care and specialty providers contracted with the MCO. In addition to reviewing the Geo Access Reports, SilverSummit staff members stated that they reviewed the provider network every two weeks in conjunction with prior authorization requests to determine the additional providers and provider types necessary to assure access for members. The policy, NV.CONT.01 Network Adequacy Selection Maintenance and Retention, included the organizations and provider types SilverSummit would partner with to assure health screenings, reproductive services, and immunizations were accessible through county and public health clinics, in addition to contracted providers. The document, 0417 NV New Member Welcome Call Script_v4, included the script that member services representatives referenced when working with Medicaid members. The script included step-by-step instructions for helping members select a PCP if they did not already have one and obtaining health services. The welcome call report showed how many calls were made to members as well as how many of those calls were answered by a member for the months of September, October, November, and December 2017. The Geo Access Report highlighted several deficiencies wherein members were without access to the following specialties and locations: behavior technicians in Reno, gastroenterology in Reno, and vascular surgery in Reno as well as in Clark County. SilverSummit staff members stated that they were aware of the deficiencies and made efforts to secure contracts with additional providers to fill the gaps in the network. SilverSummit staff members stated that the MCO signed contracts with five additional vascular surgeons, a behavioral health clinic with behavior technicians, and one additional gastroenterology provider to address the deficiencies. Four of the vascular surgery provider contracts were signed prior to July 1, 2017. One contract was signed February 23,		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	2018. The gastroenterology provider contract was signed April 20, 2018. During the on-site review, HSAG reviewers asked for an updated Geo Access Report to verify that the additional providers filled the gaps noted in the previous reports. The revised report showed that there was no longer a gap for behavior technicians, but gaps in the network still existed for gastroenterology and vascular surgery. SilverSummit staff members stated that the information for the gastroenterologist was not loaded into the system yet and that there was a mapping issue related to the provider crosswalk that fed the Geo Access Report, causing the additional vascular surgery providers to show as general surgery instead of vascular surgery providers. Since the mapping issue was not discovered until the date of the on-site review (April 24, 2018), and the quarterly Geo Access Reports generated for quarters 3 and 4 of 2017 showed deficiencies, it appeared that SilverSummit staff members were not following internal policies to use the Geo Access Reports to identify gaps in the network and take action to address the gaps in the network for the two specialties: gastroenterology and vascular surgery.		
	Recommendations: The MCO should monitor its network on a regular basis, including the use of GeoAccess mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.		
DHCFP Contract Section 3.7.5.6 (A)	14. PCP-to-Recipient Ratios The MCO must have at least one full-time equivalent (FTE) primary care provider, considering all lines of business for that provider, for every 1,500 recipients per service area. However, if the PCP practices in conjunction with a health care professional the ratio is increased to one FTE PCP for every 1,800 recipients per service area.	**Documents Submitted:** Geo Access Report **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.QI.04 Evaluation of Practitioner Availability, included the provision that SilverSummit would have at least one full-time equivalent (FTE) PCP for every 1,500 recipients per service area. The document also included the provision for each member to have access to a PCP within 25 miles from the member's place of residence. The document also described the process for the MCO's monitoring of its network to these standards.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.114(c)(1)(i) *DHCFP Contract Section 3.7.5.7 (A)*	15. Access to Emergency Services Emergency Services are provided immediately on a twenty-four (24)-hour basis, seven (7) days a week, with unrestricted access, to enrolled recipients who present at any qualified provider, whether a network provider or an out-of-network provider.	**Documents Submitted:** NV.UM.12 Emergency Services- No PLP Process SilverSummit Member Handbook, pg. 27-28 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.UM.12 Emergency Services—No PLP Process, described access to emergency services for members. The SilverSummit member handbook contained, in multiple locations throughout the document, information concerning emergency services; and the provider manual noted the requirement for emergency care.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.7 (B)	16. PCP Appointments PCP appointments are available as follows: a) Medically necessary, primary care provider appointments are available within two (2) calendar days; b) Same day, urgent care PCP appointments; and c) Routine care PCP appointments are available within two weeks. The two-week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two weeks.	**Documents Submitted:** NV.QI.05 Evaluation of the Accessibility of Services SilverSummit Healthplan Provider Manual, pg.8-10 SilverSummit Member Handbook, pg.35 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.QI.05 Evaluation of the Accessibility of Services, included the requirements for PCPs to maintain the appointment standards detailed in this element. The provider manual and member handbook also included appointment standards for PCPs.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.7 (C)(1-4)	17. Specialist Appointments For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide: a) Same day, emergency appointments within twenty-four (24) hours of referral; b) Urgent appointments within three calendar days of referral; and c) Routine appointments within 30 calendar days of referral. The MCO must allow access to a child/adolescent specialist if requested by the parents.	**Documents Submitted:** NV.QI.05 Evaluation of the Accessibility of Services SilverSummit Member Handbook, pg.36 SilverSummit Healthplan Provider Manual, pg. 8-10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.QI.05 Evaluation of the Accessibility of Services, included the requirements for the specialist appointment standards detailed in this element. The provider manual and member handbook also included appointment standards for specialists.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.7 (D)(1-4)	18. Prenatal Care Appointments Initial prenatal care appointments shall be provided for enrolled pregnant recipients as follows: a) First trimester within seven calendar days of the first request; b) Second trimester within seven calendar days of the first request;	**Documents Submitted:** NV.QI.05 Evaluation of the Accessibility of Services SilverSummit Member Handbook, pg.36 SilverSummit Healthplan Provider Manual, pg. 8-10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	c) Third trimester within three calendar days of the first request; and d) High-risk pregnancies within three calendar days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists.		
	Findings: The policy, NV.QI.05 Evaluation of the Accessibility of Services, included the requirements for this element, and the provider manual listed the access standards for prenatal care appointments.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.8 (A)	19. Appointment Standards The MCO has written policies and procedures disseminating its appointment standards to all network providers, and must assign a specific staff member of its organization to ensure compliance with these standards by the network.	**Documents Submitted:** NV.PRVR.06 Evaluation for Timely Access to Care and Services SilverSummit Healthplan Provider Manual, pg. 8-10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.PRVR.06 Evaluation for Timely Access to Care and Services, contained the requirements for this element. The policy noted that SilverSummit will disseminate Appointment Accessibility standards to providers via the provider manual. The provider manual provided included the appointment standards. The policy also described the process for monitoring to ensure appointment standards were met. Specifically, the policy described using provider surveys, telephone outreach calls, and secret shopper calls to monitor appointment standards in addition to using Geo Access Reports and grievances and appeals to monitor for issues concerning the accessing of providers or the availability of appointments. SilverSummit staff members stated that they reviewed member complaints to determine if there were complaints related to appointment standards and waiting times. Staff members stated that the medical management team will intervene and call provider offices on behalf of members to obtain timelier		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	appointments based on the urgency of the situation. The completed site visit forms maintained by SilverSummit's provider relations department provided evidence that staff members conducted site visits at provider office locations and documented the appointment wait times at the office.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.8 (B)	20. Monitoring Appointment Standards Concerning the education of its provider network regarding appointment time requirements the MCO shall: a) Monitor the adequacy of its appointment process and compliance; and b) Implement a POC when appointment standards are not met.	**Documents Submitted:** NV.PRVR.06 Evaluation for Timely Access to Care and Services Provider Visit Form **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.PRVR.06 Evaluation for Timely Access to Care and Services, described the monitoring process to ensure appointment standards were met. The policy also described the process for issuing corrective action if appointment standards were not met.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.9	21. Office Waiting Times The MCO shall establish written guidelines that a recipient's waiting time at the PCP's or specialist's office is no more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Providers are allowed to be delayed in meeting scheduled appointment times when they "work in" urgent cases, when a serious problem is found, or when the patient has an unknown need that requires more	**Documents Submitted:** SilverSummit Healthplan Provider Manual, pg.10 NV.PRVR.06 Evaluation for Timely Access to Care and Services **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	services or education than was described at the time the appointment was scheduled.		
	Findings: The policy, NV.PRVR.06 Evaluation for Timely Access to Care and Services, included the requirements for office waiting times described in this element. The provider manual also included information about office waiting times. The completed site visit forms maintained by SilverSummit's provider relations department provided evidence that staff members conducted site visits at provider office locations and documented the appointment wait times at the office.		
	Recommendations: None.		
DHCFP Contract Section 3.7.5.13	22. Prohibited Practices The MCO shall take affirmative action so that recipients are provided access to covered medically necessary services without regard to race, national origin, creed, color, gender, gender identity, sexual preference, religion, age, and health status, physical or mental disability, except where medically indicated.	**Documents Submitted:** NV.PRVR.45 Nondiscrimination in Delivery of Health Care **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.PRVR.45 Nondiscrimination in Delivery of Health Care, included the provisions related to prohibited practices such that members may not be discriminated against based on the items listed in this element. Further, the provider manual included a section titled, "Provider Responsibilities," which included the provisions that providers may not discriminate against members based on race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.		
	Recommendations: None.		
DHCFP Contract Section 3.7.6.1	23. Provider Contracts The MCO executes and maintains, for the term of the contract, written provider agreements with a sufficient number of appropriately credentialed, licensed or	**Documents Submitted:** NV.CONT.01 Network Adequacy Selection Maintenance and Retention PPA Agreement **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	otherwise qualified providers to provide enrolled recipients with all medically necessary covered services.		
	Findings: The policy, NV.CONT.01 Network Adequacy Selection Maintenance and Retention, described SilverSummit's process to establish, maintain, and monitor a sufficient network of providers to provide adequate access to all covered services for members. The document, PPA Agreement, and list of contracted providers confirmed that SilverSummit maintained a provider network that was supported by written agreements with each provider. The Geo Access Report highlighted several deficiencies wherein members were without access for the following specialties and locations: behavior technicians in Reno, gastroenterology in Reno, and vascular surgery in Reno as well as in Clark County. SilverSummit staff members stated that they were aware of the deficiencies and made efforts to secure contracts with additional providers to fill the gaps in the network. SilverSummit staff members stated that they reviewed the provider network every two weeks in conjunction with prior authorization requests to determine the additional providers and provider types necessary to assure access for members.		
	Recommendations: None.		
DHCFP Contract Section 3.7.6.5	24. Monitoring Providers The MCO must also have written policies and procedures for monitoring its providers, and complete this monitoring on its providers, and for disciplining providers who are found to be out of compliance with the MCO's medical management standards.	**Documents Submitted:** CC.QI.19 Peer Review Comm and Process NV.QI.13 Medical Record Review CC.QI.08 Preventive Health and CPG 2018 with addendum CC.CRED.07 Pract Disciplinary Actions and Reporting **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The three policies, CC.QI.19 Peer Review Committee and Process, NV.QI.13 Medical Record Review, and CC.CRED.07 Practitioner Disciplinary Action and Reporting, provided evidence of the MCO's policies and procedures for monitoring providers and implementing corrective actions against noncompliant providers.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		
DHCFP Contract Section 3.10.16.7 (A-B)	25. Steps to Assure Accessibility of Services The MCO must take steps to promote accessibility of services offered to recipients. These steps include: a) The points of access to primary care, specialty care and hospital services are identified for recipients; b) At a minimum, recipients are given information about: i. How to obtain services during regular hours of operations; ii. How to obtain emergency and after-hour care; iii. How to obtain emergency out-of-service area care; iv. How to obtain the names, qualifications and titles of the professionals who provide and are accepting medical patients and/or are responsible for their care; and v. How to access concierge services and if needed case management assistance from the vendor when needed to gain access to care.	**Documents Submitted:** SilverSummit Member Handbook https://providersearch.silversummithealthplan.com/ **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit member handbook included information concerning how to obtain services during regular hours and after hours and for emergency care both within and outside the network. The handbook also included a section about the care management (CM) services available from SilverSummit. The online provider directory enabled members to search the SilverSummit network to identify PCPs, specialists, and hospitals within their area.		
	Recommendations: None.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.17	26. Standards for Availability and Accessibility The MCO must: a) Establish standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice and recipient service lines) and complies with this RFP. b) Assess performance on these dimensions of access against the established standards.	**Documents Submitted:** NV.QI.04 Evaluation of Practitioner Availability NV.QI.05 Evaluation of the Accessibility of Services **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The two policies, NV.QI.04 Evaluation of Practitioner Availability and NV.QI.05 Evaluation of the Accessibility of Services, included the requirements noted in this element. The Member and Provider Telephone Hotline policy and procedure contained evidence of the SilverSummit call center standards for abandonment rate, average speed of answer, blocked calls, and percentage of calls answered. Interviews with staff members confirmed that monitoring of availability and accessibility would be accomplished by provider surveys, telephone outreach calls, and secret shopper calls.		
	Recommendations: None.		

Results for Standard II: Availability and Accessibility of Services							
Total	Met	=	25	X	1.00	=	25.0
	Partially Met	=	1	X	.50	=	0.5
	Not Met	=	0	X	.00	=	0.0
	Not Applicable	=	0	X	.00	=	0.0
	Total Applicable	=	26	**Total Rate**		=	25.5
Total Rate ÷ Total Applicable				**= Total Score**			98.1%

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.4.1	1. Subcontractors All Subcontracts, including delegation agreements, are in writing, are prior approved by the DHCFP, and contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract, as amended.	**Documents Submitted:** NV.CONT.01 – Network Adequacy Selection Maintenance and Retention - Policy section paragraph 3 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Network Adequacy Selection Maintenance and Retention policy included the requirements of this element. SilverSummit provided executed, written agreements for Envolve PeopleCare (nurse advice line and disease management), Envolve Pharmacy (pharmacy benefits), Envolve Vision (vision benefits), National Imaging Associates (NIA) (radiology), and Renown Health (credentialing). Copies of emails between the MCO and the DHCFP demonstrated that prior approval was obtained from the DHCFP for all delegates.		
	Recommendations: None.		
42 CFR §438.6(i)(1) *42 CFR §423.208* *42 CFR §422.210* *DHCFP Contract Section 3.7.6.6*	2. Physician Incentive Plan If the MCO has a physician incentive plan, it must comply with section 1876 of the Social Security Act and the reporting requirements outlined in 42 CFR §423.208 and §422.210, pursuant to 42 CFR §438.6(i)(1).	**Documents Submitted:** SilverSummit Provider Quality Incentive Program **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Quality Incentive Program—Medicaid document supported that the MCO had a physician incentive plan related to care coordination payments. During the on-site review, the MCO confirmed that this physician incentive plan pilot was submitted to the DHCFP prior to implementation.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.214 *42 CFR §438.6* *DHCFP Contract Section 3.15.4.1*	3. Subcontracts with Health Care Professionals The MCO complies with the requirements in 42 CFR §438.214 regarding contracts with health care professionals. The MCO ensures that all subcontracts fulfill the requirements of 42 CFR §438.6 that are appropriate to the service or activity delegated under the subcontract.	**Documents Submitted:** CC.CRED.01 Practitioner Credentialing and Recredentialing- whole policy **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: SilverSummit's credentialing program complied with the provider selection requirements found in 42 CFR §438.214.		
	Recommendations: None.		
42 CFR §438.12(a)(2) *DHCFP Contract Section 3.15.4.2*	4. MCO Oversight Requirements The MCO is responsible for oversight of all network subcontracts and is accountable for any responsibilities it delegates to any subcontracted provider (AKA, subcontractor). The MCO evaluates the prospective subcontractor's ability to perform the activities to be delegated.	**Documents Submitted:** CC.COMP.21 – Third Party Oversight Program Description **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Third Party Oversight Program Description outlined the responsibilities of business owners for overseeing and monitoring delegates and the process for mitigating performance issues. The policy further described the process for evaluating delegates. During the on-site review, the MCO provided copies of pre-delegation audit results to support MCO evaluation of the delegates' ability to perform the delegated activities.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.3	5. Prior-Approval Requirements by DHCFP All subcontracts for administrative services provided pursuant to this Request For Proposal (RFP), including, but not limited to, utilization review, quality assurance, recipient services, and claims processing, are prior-approved by DHCFP.	**Documents Submitted:** NV.COMP.100 – Page 15, section VI **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit Healthplan Compliance and Ethics Program Description 2017 included language to support that the MCO submits to the DHCFP for review and approval the names of subcontractors hired to perform any of the requirements of the contract prior to the subcontractor's effective date. Copies of emails between the MCO and DHCFP demonstrated that prior approval was obtained from the DHCFP for all delegates.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.3	6. Disclosing MCO Ownership in the Subcontracted Entity Prior to the award of any subcontract or execution of an agreement with a delegated entity, the MCO provides written information to the DHCFP disclosing the MCO's ownership interest of 5 percent or more in the subcontractor or delegated entity, if applicable. All subcontracts are submitted to DHCFP for approval prior to their effective date. Failure to obtain advance written approval of a subcontract from DHCFP results in the application of a penalty of $25,000 for each incident.	**Documents Submitted:** CC.COMP.27 – Ownership and Management Disclosure SilverSummit Form D Envolve Vision ltr SilverSummit Form D Envolve Pharmacy ltr SilverSummit Form D Envolve Peoplecare ltr **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: The Ownership and Management Disclosure policy and procedure included the requirements of this element. Additionally, the MCO provided copies of approvals from the commissioner of insurance for service agreements between the MCO and Envolve Vision, Inc.; Envolve Pharmacy Solutions, Inc.; and Envolve PeopleCare, Inc.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.4	7. Subcontractors By the service start date and whenever a change occurs, submit to DHCFP for review and approval the names of any material subcontractors the MCO has hired to perform any of the requirements of the Contract and the names of their principals.	**Documents Submitted:** NV.COMP.100 – Compliance and Ethics Program Description; top of page 15 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit Healthplan Compliance and Ethics Program Description included the requirements of this element. Copies of emails between the MCO and DHCFP demonstrated that prior approval was obtained from the DHCFP for all delegates.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.5	8. Subcontract Requirements a) The MCO maintains all agreements and subcontracts relating to the contract in writing. b) The MCO provides copies of all agreements and subcontracts to DHCFP within five (5) days of receiving such request. c) The MCO's agreements and subcontracts contain relevant provisions of the contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to	**Documents Submitted:** NV.COMP.100 – Compliance and Ethics Program Description; page 15 NVSS_EnvolvePeopleCare_Eff. 7.1.17 NVSS_EnvolvePharmacySolutions_Eff. 7.1.17 NVSS_EnvolveVision_Eff. 7.1.17 NVSS_NIA_Eff. 7.1.17 NVSS_NBH_Eff. 10.3.17 NVSS_NJH_Eff. 9.21.17	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	confidentiality, HIPAA requirements, insurance requirements and record retention. d) The MCO has the responsibility to assure that subcontractors are adequately insured to current insurance industry standards.	**Description of Process:**	
	Findings: The SilverSummit Compliance and Ethics Program Description stated that all agreements and subcontracts are in writing and that requests for copies of all agreements and subcontracts by the DHCFP would be provided within five days of receiving such requests. The master service agreements between the MCO and its subcontractors also included the services expected to be performed, and provisions related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), insurance, confidentiality, and record retention requirements.		
	Recommendations: None.		
42 CFR §438.230(b)(1) *DHCFP Contract Section 3.15.4.6*	9. Responsibility of MCO The MCO remains fully responsible for meeting all of the requirements of the Contract regardless of any subcontracts for the performance of any Contract responsibility. No subcontract operates to relieve the MCO of its legal responsibility under the Contract.	**Documents Submitted:** NV.COMP.100 – SilverSummit Healthplan Compliance Program Description – pg. 15 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Compliance and Ethics Program Description document contained statements that the MCO remains fully responsible for meeting the requirements of the contract even when contract responsibilities are delegated.		
	Recommendations: None.		
42 CFR §438.230(c)(1)(i) *DHCFP Contract Section 3.15.4.7*	10. Written Agreements The MCO must have a written agreement with the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides	**Documents Submitted:** NVSS_EnvolvePeopleCare_Eff. 7.1.17 NVSS_EnvolvePharmacySolutions_Eff. 7.1.17 NVSS_EnvolveVision_Eff. 7.1.17	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate or substandard.	NVSS_NIA_Eff. 7.1.17 NVSS_NBH_Eff. 10.3.17 NVSS_NJH_Eff. 9.21.17 **Description of Process:**	
	Findings: The agreements between the MCO and each of the subcontractors included a Statement or Scope of Work that detailed the activities delegated to the vendor. The agreements also included the reporting responsibilities and information concerning terminating the agreement or imposing sanctions and the steps that would be used to correct deficiencies in performance.		
	Recommendations: None.		
42 CFR §438.230(a)(1) *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)(iii)* *DHCFP Contract Section 3.15.4.8*	11. Monitoring Performance of the Subcontractor The MCO must monitor the subcontractor's performance on an on-going basis and subject the subcontractor to formal review according to periodic schedules established by the State, consistent with industry standards and/or State laws and regulations. If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor must take corrective action.	**Documents Submitted:** JOC Meeting Agenda_NVSS_Envolve Pharmacy_12.4.2017 JOC Meeting Minutes_Envolve Pharmacy 12.4.2017 JOC 11.17.2017_EnvolveVision minutes JOC meeting agenda_NVSS EnvolveVision_11.17.2017 JOC Meeting Agenda_NVSS EPC 11.14.2017 Envolve People Care Meeting Minutes 11.14.2017 NVSS-NBH JOC kickoff agenda NVSS-NBH JOC Kickoff Minutes 2.27.2018	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
		JOC Meeting Agenda_NVSS_NIA_11.15.2017 NIA Meeting Minutes 11.15.2017 SilverSummit Monthly Activity Dec 2017 SilverSummit Enrollment Report Dec 2017 **Description of Process:**	
	Findings: SilverSummit provided substantial documentation to support ongoing monitoring of each delegate's performance. The Joint Operating Committee (JOC) meeting minutes were detailed and supported MCO review of delegate reporting and follow-up on potential areas of concern.		
	Recommendations: None.		
DHCFP Contract Section 3.15.4.9	12. Termination of Subcontract The MCO notifies DHCFP, in writing, immediately upon notifying any material subcontractor of the MCO's intention to terminate any such subcontract.	**Documents Submitted:** NV.COMP.100 – page 15 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Compliance and Ethics Program Description indicated the MCO will notify the DHCFP in writing of any intention to terminate a subcontract agreement. During the on-site review, the MCO indicated it had not terminated any delegation agreements to date.		
	Recommendations: None.		

Standard III: Subcontracts and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.15.4.10	13. Ownership of Subcontractor Within 35 calendar days of the date of request, the MCO must provide full and complete information about the ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of request as required by 42 CFR §455.105. Failure to timely comply with the request results in withholding of payment by the State to the MCO. Payment for services cease on the day following the date the information is due and begin again on the day after the date on which the information is received.	**Documents Submitted:** CC.COMP.27 – Ownership and Management Disclosure NV.COMP.100 – page 14 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Ownership and Management Disclosure policy included the requirements of this element.		
	Recommendations: None.		

Results for Standard III: Subcontracts and Delegation						
Total	Met	= 13	X	1.00	=	13.0
	Partially Met	= 0	X	.50	=	0.0
	Not Met	= 0	X	.00	=	0.0
	Not Applicable	= 0	X	.00	=	0.0
	Total Applicable	= 13	**Total Rate**		=	13.0
Total Rate ÷ Total Applicable = Total Score						100%

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.24	1. Dispute Resolution The MCO must adequately staff a provider services unit to handle provider questions and disputes.	**Documents Submitted:** NV.MSPS.21 Member and Provider Telephone Hotline **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, CC.MSPS.21—Member and Provider Telephone Hotline, provided evidence of a call center that handled both member and provider service calls. The policy detailed the processes specific to providers and the processes specific to members. SilverSummit staff members described the provider call center, which handled all call inquires and was staffed with 23 staff members. During the on-site review, SilverSummit staff members demonstrated the system, OMNI, which was used to log and track provider inquiries. The staff members stated that they use a program called Micro-Strategy to aggregate the provider dispute information inputted in OMNI so that staff members can review the aggregate information and look for trends that may indicate a systemic problem that would need to be addressed to reduce the number of inquiries for a given issue.		
	Recommendations: None.		
DHCFP Contract Section 3.10.24.1	2. Resolving Disputes The MCO must resolve 90% of written, telephone or personal contacts within 90 calendar days of the date of receipt with appropriate follow up to provider.	**Documents Submitted:** Provider Dispute Inquiry Report **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Provider Dispute Inquiry Report provided evidence that SilverSummit tracked provider disputes monthly and resolved more than 90 percent of contacts within 90 days of receipt of the dispute. The report also contained full detail of all the complaints received by the MCO. SilverSummit staff members stated that the report was generated through Micro-Strategy, which pulled the information from OMNI.		

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		
DHCFP Contract Section 3.10.24.2	3. Log of Provider Disputes A written record in the form of a file or log is maintained by the MCO for each provider dispute to include the nature of it, the date filed, dates and nature of actions taken, and final resolution.	**Documents Submitted:** Provider Dispute Inquiry Report **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Provider Dispute Inquiry Report provided evidence that SilverSummit tracked provider disputes monthly and resolved more than 90 percent of contacts within 90 days of receipt of the dispute. The report also contained full detail of all the complaints received by the MCO. During the on-site review, SilverSummit staff members demonstrated OMNI, the system which was used to log and track provider inquiries. The OMNI system demonstration showed that staff members included comments regarding the nature of actions taken to resolve the dispute. The field in which this information was entered was a required field to resolve and close the dispute. During the on-site visit, SilverSummit staff members stated that they would modify the Provider Dispute Inquiry Report to also show the nature of actions taken for each dispute that was listed in the report.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8	4. Provider Grievances and Appeals The MCO must establish a process to resolve any provider grievances and appeals that are separate from, and not a party to, grievances and appeals submitted by providers on behalf of recipients. Written Grievance and Appeals procedures must be included, for review and approval, at the time the MCO policies and procedures are submitted to the DHCFP and at anytime thereafter when the MCO's provider	**Documents Submitted:** NV.PRVR.03 – Provider Complaints **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	grievance and appeals policies and procedures have been revised or updated. The MCO may not implement any policies and procedures concerning its provider grievance and appeal system without first obtaining the written approval of the DHCFP.		
	Findings: The policy, NV.PRVR.03—Provider Complaints, described the process that SilverSummit followed for resolving provider grievances and appeals. This process was separate from the process used by providers on behalf of members. The policy also included the provision for SilverSummit to submit the policy to the DHCFP for review and approval upon changing any aspect of it and obtain written approval from the DHCFP prior to implementing updates.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1	5. Accepting Provider Grievances and Appeals When handling Grievances and Appeals: a) The MCO must accept written or oral grievances and appeals that are submitted directly by the provider as well as those that are submitted from other sources, including the DHCFP. b) An oral appeal must be followed by a written, signed appeal; however, the oral appeal must count as the initial date of appeal.	**Documents Submitted:** NV.PRVR.03 – Provider Complaints: Page 1 section 1 & page 2 section B **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.PRVR.03—Provider Complaints, included the provision that a provider or the DHCFP may file a complaint verbally, telephonically, or in writing. The same policy required that complaints be filed within 30 days of the provider's receipt of Explanation of Payment (EOP). The policy, NV.PRVR.03— Provider Complaints, stipulated that an oral appeal must be followed by a written, signed appeal and that the date of the oral appeal would count as the initial date of complaint.		

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1	6. Written Record of Provider Grievances and Appeals The MCO must keep a written or electronic record of each provider grievance and appeal to include a description of the issue, the date filed, the dates and nature of actions taken, and the final resolution.	**Documents Submitted:** Provider Grievance Log **Description of Process:** No provider grievances to date	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Provider Grievance Log provided evidence that SilverSummit had an electronic mechanism to record and track provider grievances. SilverSummit staff members confirmed that no provider grievances had been received during the review period.		
	Recommendations: None.		
DHCFP Contract Section 3.13.8.1(A-B)	7. Timing of Final Decisions The MCO must issue a final decision, in writing, no later than: a) Ninety (90) calendar days after a grievance is filed; and, b) Thirty (30) calendar days after an appeal is filed.	**Documents Submitted:** NV.PRVR.03 – Provider Complaints: Section 2B **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The policy, NV.PRVR.03—Provider Complaints, included the provision that providers would receive resolutions to their complaints from the Claims Department within 30 days of SilverSummit's receipt of the complaint. The policy defined a "complaint" as follows: "Informal Claim Adjustment/complaint is a verbal or written expression by a Provider or from other sources, including the DHCFP, which indicates dissatisfaction or dispute with SilverSummit claim adjudication, to include the amount reimbursed or regarding denial of a particular service. An oral appeal must be followed by a written, signed appeal; however, the oral appeal date will count as the initial date of appeal." SilverSummit's process to issue a final decision within 30 days of receiving a complaint, which could include an appeal of a denial of a service, met the intent of this element.		

Standard IV: Provider Dispute and Complaint Resolution			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: None.		

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

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.8.2	1. Provider Workshops The MCO must conduct, at least annually, provider workshops in the geographic service area to accommodate each provider site. In addition to presenting education and training materials of interest to all providers, the workshops must provide sessions for each discrete class of providers whenever the volume of recent changes in policy or procedures in a provider area warrants such a session. All sessions should reinforce the need for providers to verify recipient eligibility and enrollment prior to rendering services in order to ensure that the recipient is Medicaid-eligible and that claims are submitted to the responsible entity. Individual provider site visits will suffice for the annual training requirement.	**Documents Submitted:** Provider Workshop Meeting Agenda Provider Workshop Plan **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The Provider Workshop Plan detailed SilverSummit's plan to conduct provider workshops in each geographic service area—Las Vegas and Reno. The provider relations department was the entity responsible for organizing and hosting the workshops. The Provider Workshop Meeting Agenda outlined the topics that will be discussed at the provider workshop, which will occur in June 2018.		
	Recommendations: None.		
DHCFP Contract Section 3.7.8.3	2. Provider Newsletter The MCO must publish a semi-annual newsletter for network providers. Topics may include practice	**Documents Submitted:** NVSS- Provider Newsletter Fall 17 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA

Standard V: Provider Information			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	guidelines, policy updates, quality management strategies, and other topics of provider interest.		
	Findings: The document, NVSS-Provider Newsletter Fall 2017, provided evidence that SilverSummit published a quarterly newsletter for network providers. The newsletter included information about the Healthcare Effectiveness Data and Information Set (HEDIS®)[A-1] measures; information to help members weather cold and flu season; and healthcare screenings for oral health, chlamydia, and breast and cervical cancers. The SilverSummit website also included a copy of the fall 2017 newsletter as well as the winter 2018 newsletter.		
	Recommendations: None.		
DHCFP Contract Section 3.7.8.4	3. Provider Newsletters on MCO Website The MCO must provide a copy of all newsletters to the DHCFP. Additionally, these newsletters and announcements regarding provider workshops must be published on the MCO's website.	**Documents Submitted:** https://www.silversummithealthplan.com/providers/resources/newsletters.html **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ NA
	Findings: The SilverSummit website included a copy of the fall 2017 newsletter as well as the winter 2018 newsletter. SilverSummit staff members stated that the newsletters were created quarterly and uploaded to the website once final. SilverSummit staff members stated that they will notify the providers of the workshop through the provider portal approximately three weeks prior to the workshop, which is scheduled for June 2018.		
	Recommendations: None.		

[A-1] HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

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

Compliance With Standards Review Tool CAP

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.1–3.7.5.5	13. Access and Availability The MCO shall: a) Ensure adequate physical and geographic access to covered services for enrolled recipients; b) On a quarterly basis, use geo-access mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards; c) Partner actively with DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP recipients. d) Assure access to health screenings, reproductive services and immunizations through county and state public health clinics. e) Promote care management and early intervention services by completing welcome calls and/or visits to new recipients to ensure orientation with emphasis on access to care, choice of PCP, and availability of an initial health risk screening occurs proactively with each recipient who becomes enrolled. If a	**Documents Submitted:** Geo Access Report EPSDT Log-Available On-Site EPSDT SOP PAC NV Agenda 4.23 CC.CM.01.04 New Member Welcome Calls 0417-NV New Member Welcome Call Scrip_v4 0617_New Member Orientation Script 2017 Welcome Call Report HRS Form **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ NA

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	screening risk level determines need for further care management, a care management referral will be completed.		
	Findings: The Geo Access Report provided evidence that SilverSummit monitored geographic access standards for primary care and specialty providers contracted with the MCO. In addition to reviewing the Geo Access Reports, SilverSummit staff members stated that they reviewed the provider network every two weeks in conjunction with prior authorization requests to determine the additional providers and provider types necessary to assure access for members. The policy, NV.CONT.01 Network Adequacy Selection Maintenance and Retention, included the organizations and provider types SilverSummit would partner with to assure health screenings, reproductive services, and immunizations were accessible through county and public health clinics, in addition to contracted providers. The document, 0417 NV New Member Welcome Call Script_v4, included the script that member services representatives referenced when working with Medicaid members. The script included step-by-step instructions for helping members select a PCP if they did not already have one and obtaining health services. The welcome call report showed how many calls were made to members as well as how many of those calls were answered by a member for the months of September, October, November, and December 2017. The Geo Access Report highlighted several deficiencies wherein members were without access to the following specialties and locations: behavior technicians in Reno, gastroenterology in Reno, and vascular surgery in Reno as well as in Clark County. SilverSummit staff members stated that they were aware of the deficiencies and made efforts to secure contracts with additional providers to fill the gaps in the network. SilverSummit staff members stated that the MCO signed contracts with five additional vascular surgeons, a behavioral health clinic with behavior technicians, and one additional gastroenterology provider to address the deficiencies. Four of the vascular surgery provider contracts were signed prior to July 1, 2017. One contract was signed February 23, 2018. The gastroenterology provider contract was signed April 20, 2018. During the on-site review, HSAG reviewers asked for an updated Geo Access Report to verify that the additional providers filled the gaps noted in the previous reports. The revised report showed that there was no longer a gap for behavior technicians, but gaps in the network still existed for gastroenterology and vascular surgery. SilverSummit staff members stated that the information for the gastroenterologist was not loaded into the system yet and that there was a mapping issue related to the provider crosswalk that fed the Geo Access Report, causing the additional vascular surgery providers to show as general surgery instead of		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	vascular surgery providers. Since the mapping issue was not discovered until the date of the on-site review (April 24, 2018), and the quarterly Geo Access Reports generated for quarters 3 and 4 of 2017 showed deficiencies, it appeared that SilverSummit staff members were not following internal policies to use the Geo Access Reports to identify gaps in the network and take action to address the gaps in the network for the two specialties: gastroenterology and vascular surgery.		
	Recommendations: The MCO should monitor its network on a regular basis, including the use of GeoAccess mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Response (To be completed by DHCFP/HSAG.)			