Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

Calendar Year 2022 External Quality Review Compliance Review Report

for

Anthem Blue Cross and Blue Shield Healthcare Solutions

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358 the Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid inpatient health plan's (PIHP's), or prepaid ambulatory health plan's (PAHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As DHCFP's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the contracted managed care entities (MCEs) delivering services to members enrolled in the Nevada Medicaid program. When conducting the compliance review, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The calendar year (CY) 2022 compliance review was the second year of the three-year cycle of compliance reviews that commenced in CY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews in Nevada consist of 14 program areas referred to as standards. At DHCFP's request, HSAG conducted a review of the first seven standards in Year One (CY 2021). The remaining seven standards were reviewed in Year Two (CY 2022). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Aug 3, 2022.

CY 2022 compliance reviews. Table 1-1 outlines the standards reviewed over the three-year review cycle.

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

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the MCEs' implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Member Rights and Member Information	§438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of an MCE's information systems (IS) capabilities.

Summary of Findings

Review of Standards

Table 1-2 presents an overview of the results of the CY 2022 compliance review for **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. If a requirement was not applicable to **Anthem** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards. Refer to Appendix A for a detailed description of the findings.

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	12	8	4	0	**67%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**
Standard X—Grievance and Appeal Systems	38	38	28	10	0	**74%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**134**	**131**	**115**	**16**	**3**	**88%**

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

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

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

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

Anthem achieved an overall compliance score of 88 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Provider Selection and Grievance and Appeal Systems as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **Anthem** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP is described in Section 3.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with DHCFP, performed compliance reviews of the MCEs contracted with DHCFP to deliver services to Nevada Medicaid managed care members.

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The CY 2022 compliance review is the second year of the three-year cycle of compliance reviews that commenced in CY 2021. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The compliance reviews in Nevada consist of 14 program areas referred to as standards. At DHCFP's request, HSAG conducted a review of the first seven standards in Year One (CY 2021). The remaining seven standards were reviewed in Year Two (CY 2022). In Year Three (CY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the CY 2021 and CY 2022 compliance reviews. Table 2-1 outlines the standards reviewed over the three-year review cycle.

Table 2-1—Compliance Review Standards

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the MCEs' implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of an MCE's IS capabilities.

This report presents the results of the CY 2022 review period. DHCFP and the individual MCEs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the tools was selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHCFP and the MCE as they related to the scope of the review. The review processes used by HSAG to evaluate the MCE's compliance were consistent with CMS EQR Protocol 3.

For each MCE, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with DHCFP to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the MCE a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the MCE.
- Hosted a pre-site review preparation session with all MCEs.
- Generated a list of 10 sample records for practitioner credentialing, organizational credentialing, grievances, appeals, and three sample records for delegate case file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.

- Developed an agenda for the one-day site review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted a review of practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities' records.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score of *Met*, *Not Met*, or *NA* (as described in the Data and Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

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

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.

- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

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

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

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	January 1, 2022–May 31, 2022
Information obtained through interviews	September 13, 2022
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all practitioners and organizations who completed the credentialing process between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member grievance files	Listing of all closed member grievances between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member appeal files	Listing of all closed appeals between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Nevada Medicaid managed care program between January 1, 2022–May 31, 2022

3. Corrective Action Plan Process

For any program areas requiring corrective action, **Anthem** is required to conduct a root cause analysis of the finding and submit a CAP to bring the element into compliance.

The CAP must be submitted to DHCFP and HSAG within 30 days of receipt of the final report. For each element that requires correction, **Anthem** must identify the planned interventions to achieve compliance with the requirement(s), the individual(s) responsible, and the timeline. HSAG has prepared a customized template under Appendix B to facilitate **Anthem**'s submission and DHCFP's and HSAG's review of corrective actions. The template includes each standard with findings that require a CAP.

DHCFP and HSAG will review **Anthem**'s corrective actions to determine the sufficiency of the CAP. If an action plan is determined to be insufficient, **Anthem** will be required to revise its CAP until deemed acceptable by HSAG and DHCFP.

To ensure the CAP is fully implemented, **Anthem** will be required to submit periodic progress reports on the status of each action plan. A progress report template and instructions for completing and submitting the progress reports will be provided after the approval of **Anthem**'s CAP.

Appendix A. Review of the Standards

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

Appendix A. Review of the Standards
Nevada Division of Health Care Finance and Policy
2022 MCE Compliance Review
for Anthem Blue Cross and Blue Shield Healthcare Solutions

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. *Additionally:* a. *Prior to becoming a network provider, a provider who is a non-Medicaid enrolled provider must be referred to DHCFP's fiscal agent for completion of the Medicaid provider enrollment process.* b. *The MCO may execute network provider contracts pending the outcome of the screening, enrollment, and revalidation process of up to one hundred twenty (120) calendar days but must terminate a network provider immediately upon notification from DHCFP that the network provider cannot be enrolled, or the expiration of the 120-day period without Medicaid enrollment of the provider, and notify affected members.* c. *A provider must be credentialed in accordance with the requirements of the Contract in order to become a network provider.* 42 CFR §438.214(a) 42 CFR §438.214(b)(2) 42 CFR §438.214(e) Contract 7.6.2.1; 7.6.2.2.3; 7.6.2.2.4; 7.6.2.2.7; 7.6.2.3; 7.9.6	**HSAG Recommended Evidence:** • Policies and procedures • Process documentation describing how credentialing/recredentialing information is received, stored, reviewed, tracked, and dated. • Provider enrollment process documentation **Evidence as Submitted by the MCO:** • NCQA Accreditation • Policy 1 Credentialing Program Structure, Page 3, sections ii. and iii.; Page 4, section iv. • Policy 2 Credentialing Program Provider Scope, Pages 1-5 • Policy 3 Credentials Committee, Page 1, section 2i.-ii. • Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 1, section 2.A., Pages 3-19, section 5. • Policy 4.0.1 BH - Education Criteria, Page 1, section 2; Pages 3-8, section 5. • Policy 4.0.2 Cred NP, CNM and PA, Page 1, section 2; Pages 3-10, section 5. • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 5 Initial Application, Page 1, section 2; Pages 2-10, section 5. • Policy 6 Process for Verification of Data Elements, pages 2-5, section 5	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Additional State Specific Regulatory or Contractual Requirements for Nevada, entire policy • Credentialing Systems Control Policy, page 1, section 1 • NV Medicaid Participation Verification – page 1 (Purpose)	

MCO Description of Process: Written credentialing policies and procedures describe the scope, criteria, timeliness, specific procedures for conducting credentialing and recredentialing of providers and how credentialing information is received, stored, reviewed, tracked and dated.

The Credentialing Program Structure policy provides the framework used to assure that credentialing, re-credentialing and ongoing monitoring of network practitioners and Health Delivery Organizations (HDOs) is conducted consistently and in accordance with the standards established through the National Credentials Committee (NCC).

The Credentialing Program Provider Scope policy defines the categories of Providers requiring credentialing, re-credentialing, and ongoing monitoring so as to assess whether the healthcare Providers participating in the provider network(s) meet standards of professional conduct and competence, which may be determined through Credentials committee review; or in specific situations, based upon actions taken regarding the Provider's licensure or participation in government programs such as Medicare, Medicaid or the Federal Employee Health Benefits Program (FEHBP).

The Credentials Committee (Geographic) policy establishes the responsibilities of the geographic Credentials Committee (CC) and provides a consistent methodology to review and make credentialing decisions for those providers initially applying for participation, and those reviewed for continued participation, in one or more of the programs or Provider network(s).

The Professional Competence and Conduct Criteria – Practitioners and Health Delivery Organizations (HDO) policies establish eligibility criteria regarding Professional Conduct and Competence for practitioner participation and HDO participation in the programs of provider network(s). The Behavioral Health (BH) Practitioner – Education criteria and the Credentialing of Nurse Practitioners (NPs), Certified Nurse Midwives (CNM), and Physician Assistants (Pas) policies establish criteria related to education and training for practitioners seeking initial or continued participation in the programs or provider network(s).

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
The Initial Application policy identifies the required elements and the procedures around obtaining a complete application to be completed by a Practitioner or Health Delivery Organization (HDO) applying for initial participation. The Process for Verification of Data Elements policy identifies those elements and the procedures required to be verified by the credentialing department during the credentialing or re-credentialing process for applicants that are applying for initial participation or continued participation. Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The Re-credentialing policy defines the process, time frame and procedures required for re-credentialing practitioners and Health Delivery Organizations (HDOs). The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient. The Additional State Specific Regulatory or Contractual Requirements for Nevada policy identifies any state specific or contractual requirements for a particular state as it relates to the credentialing and recredentialing processes. This policy is designed to be used in conjunction with the core Credentialing policies. State specific regulatory and contractual requirements take precedent over the requirements of the core credentialing policies for those lines of businesses affected by the state specific regulatory or contractual requirements. The credentialing process utilizes the Uniform Credentialing/Recredentialing Provider Application through the CAQH Universal Provider Data source to capture all required data and is compliant with NCQA and consistent with DHCFP requirements. The credentialing requirements meet and exceed NCQA standards, providing an excellent framework to assess the clinical competence of each credentialed provider and ensure standards are applied consistently. The Credentialing System Controls policy defines the controls in place to maintain security of the credentialing system database, how credentialing information is received, stored, reviewed, tracked and dated, and ensures that only those associates deemed necessary have access to the credentialing system database. Credentialing policies and procedures comply with NCQA, state, and federal laws and regulations, including 42 CFR 438.214 and 42 CFR 1002.3.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
NV Medicaid Participation Verification provides direction that Anthem Blue Cross Blue Shield Healthcare Solutions will only contract with providers that are approved and are actively participating with the State of NV Medicaid. This document also provides steps on determining the most current accurate status of providers with the State. Since our process is only to initiate contracting with providers after they have completed their enrollment and revalidation with the State, 1.b would not apply for initial contracting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO update its policies, procedures, and/or workflows to clearly outline the MCO's process for implementing the requirements of sub-element (b). Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.* 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing form template (link to form is acceptable) • HSAG will also use the results of the File Reviews for Form NDOI-901 use **Evidence as Submitted by the MCO:** • Policy 1 Credentialing Program Structure, Page 3, sections ii. and iii.; Page 4, section iv. • Policy 2 Credentialing Program Provider Scope, Pages 1-5 • Policy 3 Credentials Committee, Page 1, section 2i.-ii. • Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 1, section 2.A., Pages 3-19, section 5. • Policy 4.0.1 BH - Education Criteria, Page 1, section 2; Pages 3-8, section 5. • Policy 4.0.2 Cred NP, CNM and PA, Page 1, section 2; Pages 3-10, section 5.	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 5 Initial Application, Page 1, section 2; Pages 2-10, section 5. • Policy 6 Process for Verification of Data Elements, pages 2-5, section 5 • Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Additional State Specific Regulatory or Contractual Requirements for Nevada, entire policy - Caqh.org - Uniform Credentialing - Nevada Division of Insurance	

MCO Description of Process: Written credentialing policies and procedures describe the scope, criteria, timeliness, specific procedures for conducting credentialing and recredentialing of providers and how credentialing information is received, stored, reviewed, tracked and dated. These established policies and procedures help to ensure quality of care. The credentialing process utilizes the Uniform Credentialing/Recredentialing Provider Application through the CAQH Universal Provider Data source to capture all required data and is compliant with NCQA and consistent with DHCFP requirements. The NV Credentials Committee is supported by the Credentialing department, which conducts all verifications and credential file preparation.

The Additional State Specific Regulatory or Contractual Requirements for Nevada policy identifies any state specific or contractual requirements for a particular state as it relates to the credentialing and recredentialing processes. This policy is designed to be used in conjunction with the core Credentialing policies. State specific regulatory and contractual requirements take precedent over the requirements of the core credentialing policies for those lines of businesses affected by the state specific regulatory or contractual requirements.

Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required DHCFP information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
applicant's training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with DHCFP and any regulations thereunder or, if located in a jurisdiction outside of Nevada in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices. The credentialing requirements meet and exceed NCQA standards, providing an excellent framework to assess the clinical competence of each credentialed provider and ensure standards are applied consistently. Site visits are conducted for any facility that is not accredited or have a Medicare survey or that is identified on the Health Resources and Services Administration shortage designation list. Credentialing policies and procedures comply with NCQA, state, and federal laws and regulations, including 42 CFR 438.214 and 42 CFR 1002.3.		
HSAG Findings: The MCO's policy listed practitioners who were not subject to professional conduct and competency review under the MCO's credentialing program but were subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services. These practitioners included: • Certified behavioral analysts. • Certified addiction counselors. • Substance abuse practitioners. The MCO's policy also listed multiple Health Delivery Organizations (HDOs) that were not subject to professional conduct and competence review under the MCO's credentialing program but were subject to a certification requirement process. These HDOs included: • Clinical laboratories. • End Stage Renal Disease (ESRD) service providers. • Portable x-ray suppliers. • Home Infusion Therapy when associated with another currently credentialed HDO. • Hospice. • Federally Qualified Health Centers (FQHCs). • Rural Health Clinics (RHCs). MCO staff members explained that an abbreviated credentialing process would occur and that ancillary HDOs would be handled by a different team who would verify the credentials of these providers. However, in review of the MCO's contract with DHCFP, Section 7.6.2.3 of this contract requires the MCO		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
to credential and recredential providers seeking network provider status with the MCO. Therefore, all providers who have network status with the MCO, and who would be displayed as a network provider in the provider directory, must complete the MCO's formal credentialing process.		
Required Actions: The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorder (SUD), and LTSS providers. If State regulations or provider licensure laws conflict with NCQA standards, State regulations and provider licensure laws control for the credentialing process.		
Nondiscrimination		
3. The MCO network provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 Contract 7.6.2.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices **Evidence as Submitted by the MCO:** • Policy 5 Initial Application, Pages 8-10 • NV Minutes 02102022_Signed, Page 3 • 02122022 NV CC – Non-Discriminatory Audit Results • Anthem Sample Provider Agreement, Page 3; 2.2 Provider Non- Discrimination • NV_CAID Provider Manual.pdf Page 13; 4.6 Member Enrollment 4th and 5th paragraph.	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: In compliance with 42 CFR 438.214(c), discrimination is not allowed against any potential provider on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein. The credentialing process does not discriminate against (1) a health care professional solely on the basis of license or certification; or (2) a health care professional who serves high-risk populations or who specializes in the treatment of costly conditions. This information is not required or collected in the credentialing or recredentialing process. The Credentialing Committee bases their decision on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process. The Company will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices		

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in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. The MCO may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCO declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the MCO must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) Contract 7.6.2.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices • Provider notice template • Example of one individual and one organizational executed provider contracts **Evidence as Submitted by the MCO:** • NV_CAID Provider Manual, pg 25 • NV Minutes 02102022_Signed, Page 3 02122022 NV CC • Non-Discriminatory Audit Results • Anthem Sample Provider Agreement • Template welcome leter_Medicaid only • Individual Contract – Redacted • Facility Contract - Redacted	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Excluded Providers		
5. The MCO may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. a. *The MCO's written policies and procedures for its credentialing process complies with 42 CFR §1002.3* 42 CFR §438.214(d)(1) Contract 7.6.2.2.2 Contract 7.6.2.3	**HSAG Recommended Evidence:** • Policies and procedures • Three consecutive months of ongoing monitoring reports/documentation **Evidence as Submitted by the MCO:** • Policy 2 Credentialing Program Provider Scope – Pages 1, 5, and 7 • Policy 4 Professional Competence and Conduct Criteria Practitioners – Page 3 • Policy 4.1 Professional Competence and Conduct Criteria – Health Delivery Organizations – Page 4 • Policy 4.0.2 Credentialing NP, CNM and PA – Pages 5, 7, and 9 • Policy 12 Ongoing Sanction Monitoring – Pages 1, 2, and 3 (Entire Pages) • NV Federal Sanctions January 2022 – May 2022.pdf • NV Federal Tracking Log January 2022 – May 2022.pdf • NV State Sanctions January 2022 – May 2022.pdf • NV State Tracking Log January 2022 – May 2022.pdf	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: A practitioner's or HDO's participation in the Company's programs or provider network(s) may be terminated for any lawful reason, including but not limited to failure to meet standard eligibility criteria due to a lapse in basic predetermined professional conduct and competence credentialing criteria, involving licensure (revocation, suspension or surrender), required medical staff membership, privileges, certification, accreditation, or sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs. Credentialing associates perform ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listing/reports within 30 days of the time they are made available from the various sources including, but not limited to, the following:		

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Requirement	**Supporting Documentation**	**Score**
- Office of the Inspector General - Federal Medicare/Medicaid Reports - Office of Personnel Management - State licensing Boards/Agencies		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the MCO's internal policies and procedures complied with the requirements of this element, the MCO received a *Met* score. However, refer to Element 10 of this standard for additional findings.		
Required Actions: None.		
State Requirements		
6. *If the MCO denies credentialing or does not extend a provider contract to a provider where the denial is due to the MCO's concerns about provider fraud, integrity, or quality, the MCO reports this to the State's Provider Enrollment Unit within fifteen (15) calendar days.* 42 CFR §438.214(e) Contract 7.6.2.3.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of timely report to Provider Enrollment Unit (date of the denial and the date the provider was reported to the Provider Enrollment Unit must be included) **Evidence as Submitted by the MCO:** • Additional State Specific Regulatory or Contractual Requirements for: Nevada, Page 2 • 302 Submission Confirmation • ANT 302 Provider Term 04212022_04282022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Additional State Specific Regulatory or Contractual Requirements for Nevada states the following: 'If the Health Plan has denied credentialing or enrollment to a provider where the denial is due to Vendor concerns about provider fraud, integrity, or quality the Health Plan is required to report this to the State within 15 calendar days. If the Health Plan decredentials, terminates, or disenrolls a provider, the Vendor must inform the State, within 15 calendar days. If the decredentialing, termination or disenrollment of a provider is due to suspected criminal actions, or disciplinary actions related to fraud or abuse, the State must notify HHS-OIG. Anthem submits a provider term 302 report on a weekly basis to the state. This report captures any provider that has been denied/terminated. Please see the attached report as example along with the submission email corresponding to this report.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. *The MCO must have written policies and procedures for credentialing and recredentialing that are in accordance with Section 7.9.6 of the Contract.* a. *The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures.* i. *The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.* ii. *The MCO identifies those practitioners who fall under its scope of authority and action. This must include, at a minimum, all physicians and other licensed independent practitioners included in the MCO's network.* b. *Changes to the credentialing process will need to be provided in writing to the State's Provider Enrollment Unit thirty (30) calendar days prior to the change. If the change is unanticipated, the MCO will notify the State's Provider Enrollment unit within five (5) calendar days of the change.* 42 CFR §438.214(e) Contract 7.6.2.3.6; 7.9.6.2-7.9.6.4	**HSAG Recommended Evidence:** • Policies and procedures • One example of report of credentialing process change to DHCFP (the effective date of the change and the date the process change was reported to DHCFP must be provided) • Governing body approval of credentialing policies and procedures • DHCFP approval of credentialing policies and procedures • Credentialing committee charter • Three consecutive examples of credentialing committee meeting minutes **Evidence as Submitted by the MCO:** • Policy 1 Credentialing Program Structure, Page 1-2 • Policy 2 Credentialing Program Provider Scope, Page 2-5 • Policy 3 Credentials Committee, Pages 1, 5-7 • S1457 ANT Credentialing Program Submission 7.9.6 • NV Cred Committee Roster • NV Credentials Committee Minutes 01.13.2022 • NV Credentials Committee Minutes 02.10.2022 • NV Credentials Committee Minutes 03.10.2022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Credentialing Program Structure policy provides the framework used to assure that credentialing, re-credentialing and ongoing monitoring of network practitioners and Health Delivery Organizations (HDOs) is conducted consistently and in accordance with the standards established through the National Credentials Committee (NCC).		

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Requirement	**Supporting Documentation**	**Score**
The Credentialing Program Provider Scope policy defines the categories of Providers requiring credentialing, re-credentialing, and ongoing monitoring so as to assess whether the healthcare Providers participating in the provider network(s) meet standards of professional conduct and competence, which may be determined through Credentials committee review; or in specific situations, based upon actions taken regarding the Provider's licensure or participation in government programs such as Medicare, Medicaid or the Federal Employee Health Benefits Program (FEHBP). The Credentials Committee (Geographic) policy establishes the responsibilities of the geographic Credentials Committee (CC) and provides a consistent methodology to review and make credentialing decisions for those providers initially applying for participation, and those reviewed for continued participation, in one or more of the programs or Provider network(s).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the MCO provided evidence of submitting credentialing policies to DHCFP, several policies were revised after the submission. MCO staff members explained that they would only submit the policies to DHCFP for substantial changes impacting Nevada Medicaid. **Recommendations:** HSAG recommends that the MCO update its policies, procedures, and/or workflows to clearly outline the MCO's process for implementing the requirements of sub-element (b). Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
8. *If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities, there must be a written description of the delegated activities, and the delegate's accountability for these activities.* a. *There must be evidence that the delegate accomplished the credentialing activities.* b. *The MCO must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.* 42 CFR §438.214(e) Contract 7.6.2.3.7	**HSAG Recommended Evidence:** • Policies and procedures • Delegation agreement template • Two examples of an executed delegation agreement for credentialing • Two examples of evidence to demonstrate credentialing monitoring, including credentialing completion oversight **Evidence as Submitted by the MCO:** • Delegate Vendor Oversight and Management Program, pg 2 • EyeQuest 2022 Cred AA • EyeQuest Semi-Annual Reporting 2021 • Aspire 2022 CR AA • Anthem 2nd Semi-Annual Reporting Form 2021	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Elevance Health (fka Anthem) Master Services Agreement Template • Aspire-NV-MOU-09.22.2020_Redacted	
MCO Description of Process: There are no examples of an executed delegation agreement for credentialing within the applicable look back period. We have included Aspire, however, the most recent amendment is from 2020.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
File Reviews		
9. The MCO complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214(e) Contract 7.6.2.3.1; 7.6.2.3.2	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Site review process flow • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Practitioner Credentialing File Reviews	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the MCO: • Policy 2 Credentialing Program Provider Scope, Pages 1-5 • Policy 3 Credentials Committee, Page 1, section 2i.-ii. • Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 1, section 2.A., Pages 3-19, section 5.	

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Requirement	**Supporting Documentation**	**Score**
	• Policy 4.0.1 BH - Education Criteria, Page 1, section 2; Pages 3-8, section 5. • Policy 4.0.2 Cred NP, CNM and PA, Page 1, section 2; Pages 3-10, section 5. • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 5 Initial Application, Page 1, section 2; Pages 2-10, section 5. • Policy 6 Process for Verification of Data Elements, Pages 2-10 • Policy 6.1 Distribution of Appropriate Information Related to Practitioner Education_Training_Certification • Policy 7 Site Visits • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Template welcome letter_Medicaid only • Caqh.org • Uniform Credentialing - Nevada Division of Insurance • [provider name]_Certified Letter.pdf • [provider name]_Certified Letter.pdf • [provider name]_Certified Letter.pdf	
MCO Description of Process: The credentialing of network providers is an important component of the quality management process. We use this process to monitor that all in scope providers and organizations that we contract with to provide services to our NV members are qualified to perform those services and deliver the best possible care. Each provider has a standard unique health identifier. We have the systems, employees, and policies and procedures in place to accurately and timely credential and re-credential the full spectrum of physical and behavioral health providers in compliance with the DHCFP requirements.		

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Requirement	**Supporting Documentation**	**Score**
The Credentialing Program Structure policy provides the framework used to assure that credentialing, re-credentialing and ongoing monitoring of network practitioners and Health Delivery Organizations (HDOs) is conducted consistently and in accordance with the standards established through the National Credentials Committee (NCC). The Credentialing Program Provider Scope policy defines the categories of Providers requiring credentialing, re-credentialing, and ongoing monitoring so as to assess whether the healthcare Providers participating in the provider network(s) meet standards of professional conduct and competence, which may be determined through Credentials committee review; or in specific situations, based upon actions taken regarding the Provider's licensure or participation in government programs such as Medicare, Medicaid or the Federal Employee Health Benefits Program (FEHBP). The Professional Competence and Conduct Criteria – Practitioners and Health Delivery Organizations (HDO) policies establish eligibility criteria regarding Professional Conduct and Competence for practitioner participation and HDO participation in the programs of provider network(s). The Behavioral Health (BH) Practitioner – Education criteria and the Credentialing of Nurse Practitioners (NPs), Certified Nurse Midwives (CNM), and Physician Assistants (Pas) policies establish criteria related to education and training for practitioners seeking initial or continued participation in the programs or provider network(s). The Initial Application policy identifies the required elements and the procedures around obtaining a complete application to be completed by a Practitioner or Health Delivery Organization (HDO) applying for initial participation. The Process for Verification of Data Elements policy identifies those elements and the procedures required to be verified by the credentialing department during the credentialing or re-credentialing process for applicants that are applying for initial participation or continued participation. Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The Distribution of Appropriate Information Related to Practitioner Education, Training and Certification outlines the manner in which data received, verified and assessed in the credentialing process is managed so as to maintain its integrity. Additionally, the policy provides mechanisms to support that practitioner information made available to members is consistent with that which has been obtained from practitioner and verified through the credentialing process. This policy specifically addresses information related to practitioner education, training, certification and specialty. The Site Visits policy establishes the standards used to assess the physical accessibility, appearance of the office sites, and adequacy of the waiting and examination rooms of all network Practitioners. This policy applies to credentialed Practitioners where there is an accreditation or regulatory requirement		

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Requirement	**Supporting Documentation**	**Score**
regarding site visits. The policy establishes the criteria for assessing these issues and the procedure to perform site visits and monitor compliance with corrective actions after receiving a member complaint regarding these issues. The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The case file review identified inconsistencies in querying the Social Security Administration (SSA) Death Master File (DMF). For example, four case files confirmed the SSA DMF was queried; however, one case file documented "NA" for the SSA DMF query. After the site review, the MCO explained that the SSA DMF would not have been applicable on the initial checklist as the provider was initially credentialed for the MCO's commercial line of business (LOB). The MCO also submitted evidence that the SSA DMF was queried on April 4, 2022, for "Add-a-Plan of NV Medicaid" that occurred prior to the credentialing decision; however, it remains unclear why the credentialing checklist would not have been updated with this information. As the MCO's contract with DHCFP did not stipulate that the SSA DMF must be queried at the time of credentialing, this observation was not considered a deficiency; however, HSAG will be recommending that DHCFP identify the databases which must be queried in contract for consistency across the managed care plans for Nevada Medicaid. The case file review also identified inconsistencies in the documentation of State Medicaid sanctions. While verification of State Medicaid sanctions was documented on the checklist for all files, proof of the Nevada sanction list query was only located in one of the files. As such, HSAG recommends that the MCO include all proofs of verification in the case files. Further, while the MCO adhered to its internal credentialing time frame standard, HSAG will be recommending that DHCFP define a time frame standard to complete the initial credentialing process (e.g., 60 or 90 calendar days from receipt of a complete application to the notice of the credentialing decision to the provider) for consistency across the managed care plans for Nevada Medicaid. One credentialing file listed an alternative prescriber for a provider. HSAG requested evidence that the MCO verified the alternative prescriber's credentials and in follow-up, the MCO confirmed it had no additional documentation to submit. As completing verifications of alternative prescribers was not a scoring element, this observation was not considered a deficiency. However, not validating the credentials of alternative prescribers is a risky practice. HSAG will be recommending that DHCFP include minimum verifications for alternative prescribers as a credentialing contract requirement (e.g., State license, Drug Enforcement Administration [DEA] certification, State of Nevada Board of Pharmacy [BOP] registration, Nevada Medicaid enrollment, Medicare/Medicaid sanctions/exclusions). The MCO must be prepared to demonstrate compliance with any additional credentialing provisions that may be added to its contract with DHCFP during future compliance reviews. HSAG also recommends that the MCO consistently conduct primary source verification (PSV) on all State licenses, whether active or inactive. Additionally, for one case, the approval notice to the provider was not located. After the site review, the MCO explained that providers would receive notices via the provider system that they are able to review. A screen shot of "Provider Tickets Comments" from the provider solutions team was provided; however, HSAG would have expected the MCO to		

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Requirement	**Supporting Documentation**	**Score**
submit the actual communication viewable to the provider. HSAG recommends that the MCO ensure these communications are submitted during future compliance reviews. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
10. The MCO complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214 Contract 7.6.2.3.4	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Quality data review process documentation, including source data • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Practitioner Recredentialing File Reviews **Evidence as Submitted by the MCO:** • Policy 2 Credentialing Program Provider Scope, Pages 1-5 • Policy 3 Credentials Committee, Page 1, section 2i.-ii. • Policy 6 Process for Verification of Data Elements, Pages 2-10 • Policy 6.1 Distribution of Appropriate Information Related to Practitioner Education_Training_Certification • Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Caqh.org	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Uniform Credentialing - Nevada Division of Insurance • Nevada Process – Quality of Care-Adverse Events Review.pdf • Quality of Care – Core Procedure.pdf	

MCO Description of Process: All applicable Practitioners and Health Delivery Organizations (HDOs) are required to be re-credentialed at least every three (3) years, unless otherwise required by contract or state regulations. The re-credentialing process incorporates re-verification and identification of changes in the provider's licensure, sanctions, certification, health status and/or performance information (including but not limited to malpractice experience, hospital privilege or other actions) that may reflect upon the providers' professional conduct and competence.

The Credentialing Program Provider Scope policy defines the categories of Providers requiring credentialing, re-credentialing, and ongoing monitoring so as to assess whether the healthcare Providers participating in the provider network(s) meet standards of professional conduct and competence, which may be determined through Credentials committee review; or in specific situations, based upon actions taken regarding the Provider's licensure or participation in government programs such as Medicare, Medicaid or the Federal Employee Health Benefits Program (FEHBP).

The Credentials Committee (Geographic) policy establishes the responsibilities of the geographic Credentials Committee (CC) and provides a consistent methodology to review and make credentialing decisions for those providers initially applying for participation, and those reviewed for continued participation, in one or more of the programs or Provider network(s).

The Process for Verification of Data Elements policy identifies those elements and the procedures required to be verified by the credentialing department during the credentialing or re-credentialing process for applicants that are applying for initial participation or continued participation. Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards.

The Distribution of Appropriate Information Related to Practitioner Education, Training and Certification outlines the manner in which data received, verified and assessed in the credentialing process is managed so as to maintain its integrity. Additionally, the policy provides mechanisms to support that practitioner information made available to members is consistent with that which has been obtained from practitioner and verified through the credentialing process. This policy specifically addresses information related to practitioner education, training, certification and specialty.

The Re-credentialing policy defines the process, time frame and procedures required for re-credentialing practitioners and Health Delivery Organizations (HDOs) in provider network(s).

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Requirement	**Supporting Documentation**	**Score**
The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient. The Quality of Care policy is to ensure quality and appropriateness of care rendered by monitoring for potential or identified Quality of Care (QOC) issues on an on-going basis.		
HSAG Findings: The case file review identified one recredentialing file in which the provider was identified as being excluded from participation in a State/federal government program, and a termination letter sent to the provider dated June 7, 2022, indicated that the provider was excluded since September 20, 2020. The credentialing file also included documentation that confirmed the provider was listed on the Preclusion List, yet the provider was approved for participation. This demonstrated that the MCO included this provider in its network for over 20 months after the provider was excluded and also indicated a gap in the MCO's ongoing monitoring of provider sanctions and exclusions. After the site review, the MCO explained that this provider was credentialed for another LOB and not Nevada Medicaid. HSAG requested proof of this statement and in follow-up, the MCO submitted a document that demonstrated the provider was terminated from the Nevada Medicaid network effective June 10, 2021 for failing to revalidate Medicaid enrollment with the State. The MCO also clarified that updating its credentialing data with this information was missed. Further, while the provider was termed from the Medicaid LOB effective June 10, 2021, the credentialing case file confirmed that the provider was excluded since September 20, 2020; therefore, the provider had been a provider for the MCO's Medicaid LOB for a period of almost nine months while being excluded from Medicare/Medicaid participation. As the MCO's credentialing database was not updated with the termination and the credentialing file indicated that the provider was approved on April 14, 2022, for various networks, including Nevada Medicaid, the provider appears to have been a provider for the MCO's Nevada Medicaid LOB until June 7, 2022. **Recommendations:** As the findings for this element suggest a potential serious concern in the MCO's process for monitoring for Medicare/Medicaid exclusions at the time of credentialing and on an ongoing basis, HSAG recommends that the MCO conduct a comprehensive review of its credentialing processes to determine if this case was an anomaly or whether a more serious breach in the MCO's process occurred. Additionally, the checklists in the recredentialing case files confirmed that a performance review of "Member Satisfaction/Member Complaints" and "Quality/UM/Grievance Issues" occurred; however, the MCO's policies lacked specific details on the thresholds, data sources reviewed, and the process for querying this information at the time of recredentialing. As such, HSAG recommends that the MCO update its policies, procedures, and/or workflows to clearly outline this process. The MCO should also be prepared to demonstrate a walk-through of the credentialing specialist's (and/or other applicable staff) process, including the data queried at the time of recredentialing during future compliance reviews. Implementation of these recommendations will be evaluated during future compliance reviews.		

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Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCO must comply with individual practitioner credentialing requirements as required by its contract with DHCFP.		
11. The MCO complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Credentialing File Reviews **Evidence as Submitted by the MCO:** • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 5 Initial Application, Page 1, section 2; Pages 2-10, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Template welcome letter_Medicaid only	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The Professional Competence and Conduct Criteria – Health Delivery Organizations policy establishes eligibility criteria regarding professional conduct and competence for Health Delivery Organizations (HDOs) and the HDO's participation in the program or provider network(s). This policy also defines the process and standards by which HDOs within the scope of the Company's credentialing program are initially assessed for participating in the Company provider network(s). The credentialing of Health Delivery Organizations (HDOs) is an important component of the quality management process. This process is utilized to monitor that all cred in scope organizations contracted with to provide services to NV members are qualified to perform those services and deliver the best possible care. Each HDO has a standard unique health identifier. Systems, associates, and policies and procedures are in place to accurately and timely credential and re-credential the full spectrum of physical and behavioral health providers in compliance with the DHCFP requirements.		

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Requirement	**Supporting Documentation**	**Score**
The Initial Application policy identifies the required elements and the procedures around obtaining a complete application to be completed by a Practitioner or Health Delivery Organization (HDO) applying for initial participation. The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient.		
HSAG Findings: The case file review identified one record in which the Preclusion List and the System for Award Management (SAM) queries occurred after the credentialing decision date. HSAG requested follow-up to this finding; after the site review, the MCO confirmed it had no additional documentation to submit. **Recommendations:** While disclosure of ownership and control interest forms were included in the credentialing files, the files did not include verification that any disclosed individuals and entities were also screened for Medicare and Medicaid sanctions. MCO staff members explained that these checks are the responsibility of a different team outside of credentialing. As such, HSAG recommends that the MCO be prepared to demonstrate this process during future compliance reviews.		
Required Actions: The MCO must credential all organizational provider types applying for provider network status in accordance with the MCO's contract with DHCFP. All verifications must occur prior to the credentialing decision.		
12. The MCO complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Recredentialing File Reviews **Evidence as Submitted by the MCO:** • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5.	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5.	

MCO Description of Process: The Professional Competence and Conduct Criteria – Health Delivery Organizations policy establishes eligibility criteria regarding professional conduct and competence for Health Delivery Organizations (HDOs) and the HDO's participation in the program or provider network(s). This policy also defines the process and standards by which HDOs within the scope of the Company's credentialing program are initially assessed for participating in the Company provider network(s). The credentialing of Health Delivery Organizations (HDOs) is an important component of the quality management process. This process is utilized to monitor that all cred in scope organizations contracted with to provide services to NV members are qualified to perform those services and deliver the best possible care. Each HDO has a standard unique health identifier. Systems, associates, and policies and procedures are in place to accurately and timely credential and re-credential the full spectrum of physical and behavioral health providers in compliance with the DHCFP requirements.

The Re-credentialing policy defines the process, time frame and procedures required for re-credentialing practitioners and Health Delivery Organizations (HDOs) in provider network(s).

The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient.

HSAG Findings: The case file review identified that one file for a laboratory provider only included a Clinical Laboratory Improvement Amendments (CLIA) certificate of compliance. No other information was provided; and while the CLIA was active, documentation did not include a verification date. MCO staff members explained that this provider was credentialed by the MCO's delegate. After the site review, the MCO provided an email thread between the MCO and its delegate wherein the MCO was requesting additional information related to a coversheet or evidence of an approval date, and if the delegate performed sanction monitoring on individual laboratories. The delegate explained that it performs monthly exclusion checks of employees, officers, contingent workers, contractors, vendors, and laboratories. The MCO further explained that the credentialing file is different than the typical credentialing cycle of a facility due to the unique circumstances regarding Labcorp and their owned laboratory facilities. No other information was provided, and the credentialing expectations for laboratory provider types remain unclear. Further, this provider is licensed by the Nevada Division of Public and Behavioral Health (DPBH) with a first issue date of June 6, 2022. While no documentation was provided to confirm the recredentialing date for

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
this provider, the universe file reported the date as May 19, 2022. Therefore, the provider appeared to have been recredentialed (and initially credentialed) without the provider having a Nevada DPBH license. **Recommendations:** HSAG recommends that the MCO conduct a comprehensive review and create a crosswalk of all organizational providers and the Nevada-specific licensing requirements for those providers. The MCO must ensure all providers meet state-specific requirements during credentialing. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must credential all organizational provider types applying for provider network status in accordance with the MCO's contract with DHCFP. The MCO must verify that each provider is in good standing with Nevada-specific regulatory bodies.		

Standard VIII—Provider Selection						
Met	=	8	X	1	=	8
Not Met	=	4	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	12	Total Score		=	8
Total Score ÷ Total Applicable					=	67%

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO must, for medical records and any other health and enrollment information that identifies a particular member, use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. The MCO must: a. *Establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records.* b. *Ensure patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.* c. *Hold confidential all information obtained by its personnel about members related to their examination, care, and treatment and shall not divulge it without the member's authorization, except as required or permitted by law.* 42 CFR §438.224 Contract 7.4.8; 7.9.9.1-7.9.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Disclosure form(s) • Staff and provider training materials • Provider contract template • Staff and provider monitoring documentation **Evidence as Submitted by the MCO:** Privacy Program Management Policy: pg1 Safeguards Policy: pg 1 to 5 Individual Representative and Deceased Member Policy: pg 1,#1 Verification and Authentication Policy: pg 1& 2 MF-ANV-0011-17 NV PRV HIPAA Authorization Form Training_Protecting Information_Everyone's Responsibility Anthem Sample Provider Agreement: pg 6; Sec 3.2 & 3.3 NV_CAID Provider Manual: pg 70; Sec 7.15 2021 Anthem Code of Conduct, Pg 14	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Uses and Disclosures of PHI		
2. The MCO and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCO is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCO has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1) Contract 7.9.9.3.1-7.9.9.3.3; 7.9.9.4; 7.9.9.5	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template • Delegate agreement/contract • HIPAA incident tracking mechanism **Evidence as Submitted by the MCO:** Minimum Necessary Requirements Policy: pg1, item 2 Privacy Program Management Policy: pg 1 Safeguards Policy: pgs 1 to 5 Disclosure to Third Parties Policy_Pg1 2022 DTRT Certification Module: Pg5 Vendor BAA C360 Incident Submittal Page (Screen Shots) 2021 Anthem Code of Conduct, Pg 14	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
3. The MCO, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCO's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2-4)	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for processing requests • Training materials • Business associate agreement template **Evidence as Submitted by the MCO:** Access to Protected Health Information Amendment and Accounting of Disclosure Policy: pgs 1-3 Right to File Privacy Complaint Policy: pg1 2022 DTRT Certification Module: Pg5 Vendor BAA	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Minimum Necessary		
4. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCO must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the MCO:** Minimum Necessary Requirements Policy: pg 1, 1st paragraph 2022 DTRT Certification Module: Pg5, 2.3 Training_Protecting Information_Everyone's Responsibility Pgs 44, 46, 52	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The MCO will only collect, use, and disclose the minimum amount of Protected Health Information as necessary to perform permitted functions.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
5. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 45 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law. f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR. 45 CFR §164.502(b)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the MCO:** Minimum Necessary Requirements Policy: pg 1, #2 2022 DTRT Certification Module: Pg5 Training_Protecting Information_Everyone's Responsibility Pgs 44, 46, 52	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Uses and Disclosures Requiring Authorizations		
6. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity must provide the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4)	**Evidence as Submitted by the MCO:** Individual Representative and Deceased Member Policy: pg1, item 1 2022 DTRT Certification Module: Pg5 Training_Protecting Information_Everyone's Responsibility Pg 25 MF-ANV-0011-17 NV PRV HIPAA Authorization Form	
MCO Description of Process: The MCO will not use or disclose PHI without a valid authorization except as otherwise permitted or required by law. In the circumstances where MCO receives completed HIPAA authorization forms from our members, it is not at our request but is instead initiated by the individual. Therefore, we receive our copy directly from the individual so the member would already have a copy of the signed authorization and would not require another.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** After the site review, MCO staff members provided screen shots to show how information is captured prior to releasing protected health information (PHI). The screen shots appeared to indicate that the parent of an adult child and stepparents or other family members could be documented as informal representatives. Although it is not clear whether the MCO is releasing PHI to these informal representatives without member consent, HSAG strongly recommends that MCO staff members ensure that PHI is only being released in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) expectations, which would require signed authorization from the member or member's legal guardian (or verbal authorization in some instances) to release information to anyone who is not the member or the member's legal representative. Additionally, the MCO's HIPAA Authorization Form included a statement, "keep a copy for your records"; however, the MCO indicated in its description of process and during the site review that the authorization is typically initiated from the individual and not at the request of the MCO. After the site review, the MCO provided an example of a signed authorization that was initiated at the request of the MCO in order for the MCO to share the member's story. The member's signature acknowledged that "I [the member] am entitled to a copy of this authorization to release"; however, it was not clear whether the MCO provided a copy of the signed authorization as required by this element. As such, HSAG strongly recommends that the MCO ensure its process when seeking an authorization from a member to use or disclosure PHI includes providing the member with a copy of the signed authorization. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Privacy Rights		
7. The MCO complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the MCO:** Right to Request Restrictions Policy and Procedure: pgs.1,2 & 3 Member Handbook Pg 84-87, HIPAA Notice of Privacy Practices 2022 DTRT Certification Module: Pg5 Training_Protecting Information_Everyone's Responsibility Pg 61 Member Privacy Unit Book (Screen Captures) MF-ANV-0001-17 NV PRV Restriction Info Form	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There has not been any requests within the applicable look back period for this audit, therefore we are unable to supply three examples of completed/documented requests. However, we are able to provide the screen captures within the Member Privacy Unit Book that shows the process flow on how these requests would be handled and tracked in our system. These must be sent to the Privacy Liaison for handling.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
8. The MCO complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The MCO must act on a request for access no later than 30 days after receipt of the request.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
b. The MCO must provide the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCO and member. 45 CFR §164.524	• Request form template • Three examples of completed request documentation **Evidence as Submitted by the MCO:** Access to Protected Health Information Amendment and Accounting of Disclosure Policy and Procedure: pg6, H1, H2b_1,2 Member Handbook Pg 85, What are your rights? MF-ANV-0058-20 ANV PRV Access to Records Form	
MCO Description of Process: There has not been any requests within the applicable look back period for this audit, therefore we are unable to supply three examples of completed/documented requests.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The Access to Protected Health Information, Amendment, and Accounting of Disclosures Policy and Procedure indicated: Anthem's Privacy Department has created a Forms Toolkit for Individual Rights to serve as a resource/tool to assist in the management of Individual rights within Anthem. In addition to the toolkit, please reference the Individual Rights policies and your designated business unit's desktop procedures when Individual members are invoking these rights. If you have any questions or concerns regarding Individual Rights of members, please contact your Privacy Liaison. MCO staff members explained that individual rights requests are not being handled by the Privacy Department but instead are being managed by designated staff in the customer service department. Although the MCO had processes in place to provide records to members promptly when requested, during the site review, MCO staff members explained that "informal" access to PHI requests were not being tracked in the system. HSAG is not clear on what types of access requests would be considered "informal" requests; however, HSAG strongly recommends that the MCO's privacy officer and/or other qualified privacy staff monitor and maintain oversight of the teams tasked with completing individual rights requests and ensure that all member rights requests under HIPAA are being documented, tracked, and completed in compliance with HIPAA requirements. HSAG also strongly recommends that the MCO's organizational charts and HIPAA policies clearly depict which MCO employee is responsible for completing each individual right request and who is overseeing the staff members responsible for completing the requests. Please note that this recommendation applies to elements 7–10 of this standard, and the implementation of these recommendations will be reviewed during future compliance reviews.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
9. The MCO complies with the member's right to have the MCO amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCO complies with the requirements under 45 CFR §164.526. a. The MCO must act on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the MCO:** Access to Protected Health Information Amendment and Accounting of Disclosure Policy and Procedure: pg15, G1 Member Handbook Pg 85, What are your rights? MF-NV-0055-17 PRV Amendment Request Form	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There has not been any requests within the applicable look back period for this audit, therefore we are unable to supply three examples of completed/documented requests.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. The MCO complies with the member's right to receive an accounting of disclosures of PHI made by the MCO in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The MCO must act on the member's request for an accounting, no later than 60 days after receipt of such a request.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
b. The MCO must document the accounting of disclosures and retain the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528	**Evidence as Submitted by the MCO:** Access to Protected Health Information, Amendment and Accounting of Disclosure Policy & Procedure: pg11, 2C5 & D1 Member Handbook Pg 85, What are your rights? Training_Protecting Information_Everyone's Responsibility Pg 61 MF-ANV-0002-17 NV PRV Accounting Disclosures Form	
MCO Description of Process: The MCO addresses a request for an accounting of disclosures and provide response to the member within 60 days of receipt of the request. There has not been any requests within the applicable look back period for this audit, therefore we are unable to supply three examples of completed/documented requests.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** After the site review, MCO staff members provided the Accounting of Disclosures Report DTP procedure, which indicated that the privacy professional will run a report to identify any privacy or security incidents, disclosures documented in the Corporate Individual Rights System (CIRS) according to the Specialized Disclosures Policy, and information on the All Payer Claims databases. The procedure also indicated that accounting of disclosures reports are run in Business Objects, Compliance 360, GBD Facets, and CIRS. During the site review, MCO staff members indicated that disclosures would be documented in Facets; however, they were unable to clearly articulate the process for doing so. Although the MCO's policies and procedures aligned with HIPAA requirements for the member's right to receive an accounting of disclosures (and therefore this element was scored as *Met*), HSAG strongly recommends that MCO staff members be trained on the disclosures required to be tracked (e.g., reports made to Adult Protective Services) and where specifically each type of disclosure should be entered to ensure that the Privacy Team is able to pull a complete accounting of disclosures on member request. Implementation of this recommendation will be evaluated during future compliance reviews. Additionally, for future compliance reviews, HSAG also strongly recommends that Privacy Department representatives participate in the interview sessions.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Notice of Privacy Practices		
11. The MCO's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCO, and of the member's rights and the MCO's legal duties with respect to PHI. a. The MCO must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The MCO must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1)(i-viii) 45 CFR §164.520(c)(1-3)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form • Copy of notice of privacy practices **Evidence as Submitted by the MCO:** Notice Policy: pg1_a through r; pg3_4a_1&2 Training_Protecting Information_Everyone's Responsibility Pg 61 MF-ANV-0011-17 NV PRV HIPAA Authorization Form Member Handbook Pg 84-87, HIPAA Notice of Privacy Practices	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The MCO provides members a right to a notice describing the uses and disclosures of PHI that may be made by the MCO.		
HSAG Findings: Although the Notice policy outlined the required content of a Notice of Privacy Practices, a review of the notice on the website indicated the following gaps: • The notice must contain the following statement as a header or otherwise prominently display, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY." The MCO's notice did not include this specific statement as required. Instead, it indicated, "Please read this notice carefully. This tells you: Who can see your protected health information(PHI). When we have to ask for your OK before we share your PHI. When we can share your PHI without your OK. What rights you have to see and change your PHI." According to the Federal Register, this is the only verbatim language covered entities must include in the notice. Please refer to https://www.federalregister.gov/documents/2000/12/28/00-32678/standards-for-privacy-of-individually-identifiable-health-information. • The notice must contain a description, including at least one example of the types of uses and disclosures that the covered entity is permitted by this subpart to make for each of the following purposes: treatment, payment, and health care operations. Although the notice included a section, "When it is OK for us to use and share your PHI," and under the header, this bullet, "For payment, healthcare operations, and treatment," and statements under the bullet describing when the MCO would disclose information (e.g., "to share information with the doctors, clinics, and others who bill us for your care"), the descriptions were not tied directly to treatment, payment, or health care operations, making it challenging for a member to understand each purpose.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
• The notice must contain a description of the types of uses and disclosures that require an authorization under §164.508(a)(2)-(a)(4), which would include uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures that involve the sale of PHI. Although the noticed indicated, "we have to get your written OK before we share psychotherapy notes from your doctor about you," the notice did not indicate authorization is required for marketing and the sale of PHI. **Recommendations:** After reviewing the Notice of Privacy Practices published on the MCO's website, HSAG discovered that the notice indicated March 21 as the last revision date. However, the member handbook, effective January 1, 2022, included a HIPAA Notice of Privacy Practices that indicated the notice was revised January 5, 2018, implying that members did not receive the most current version of the notice. During the site review, MCO staff members indicated that this was a material change but later confirmed that none of the changes between the version on the website and the version provided to members as part of the handbook constituted a material change. However, HSAG recommends that the MCO update its member handbook to include the most current version of the Notice of Privacy Practices. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must ensure the Notice of Privacy Practices includes all the required components as indicated in 45 CFR §164.520(b)(1)(i–viii).		

Standard IX—Confidentiality						
Met	=	10	X	1	=	10
Not Met	=	1	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	11	Total Score		=	11
Total Score ÷ Total Applicable					=	91%

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. *The MCO has a staff person dedicated to the Contract who acts as the Grievances and Appeals Coordinator to manage member and provider disputes arising from the MCO's Grievance and Appeals System.* a. *The MCO shall have sufficient support staff (clerical and professional) available to process grievance and appeals in accordance with the requirements of the Contract.* Contract 7.2.1.2.12; 7.8.10.5.6	**HSAG Recommended Evidence:** • Job description • Organizational chart • Training materials **Evidence as Submitted by the MCO:** NV G&A Job Descriptions NV G&A Organizational Chart NV Medical Necessity Appeals Policy, All Pages NV Member Grievance Resolution Policy, All Pages	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem Grievance and Appeals (G&A) has dedicated and knowledgeable staff that oversees and is responsible for the G&A System in accordance with the requirements of the Contract. Anthem dedicated G&A staff is in the NV G&A Job Descriptions and NV G&A Organizational Chart. This is further demonstrated in the NV Medical Necessity Appeals Policy and the NV Member Grievance Resolution Policy.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. The MCO defines a grievance as an expression of dissatisfaction *or making a complaint* about any matter other than an adverse benefit determination (ABD)*, regardless of whether the communication requests any remedial actions*. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Page 2 NV Member Handbook, Page 82	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
extension of time proposed by the MCO to make an authorization decision. 42 CFR §438.400(b) 42 CFR §438.228 Contract 7.8.10.2		
MCO Description of Process: Anthem G&A follows the grievance definition in accordance with federal and Contract requirements. This is further demonstrated in the NV Member Grievance Resolution Policy, Page 2 and the NV Member Handbook, Page 82.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The Member Grievance Resolution – NV policy included the appropriate definition of "grievance," but the policy also included a definition for "inquiry" as "A member request for information or an issue that is resolved promptly during the initial telephone call by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the member." The member handbook also indicated, "If you have a problem with our services or network providers, we would like you to tell us about it. Please call member services and we will try to solve your problem on the phone. If we cannot take care of the problem when you call us, you can file a grievance." The definition of "grievance" under federal rule is "an expression of dissatisfaction about any matter other than an adverse benefit determination," and the grievance system means the process the MCO implements to handle grievances, as well as the processes to collect and track information about them. Although the MCO provided assurances that it is handling all expressions of dissatisfactions appropriately and therefore received a *Met* score for this element, HSAG strongly recommends that the MCO ensure that all expressions of dissatisfaction, whether they are resolved or not through the initial telephone call, are tracked and handled through the grievance process. Additionally, the MCO has implemented a second-level grievance process. Although HSAG has no concerns that the MCO is reviewing grievances a second time, the MCO must ensure that language within its grievance resolution letters does not impede members' rights to file a grievance at any time. The resolution letter currently indicates that members must submit a written request for a second-level grievance review within 90 calendar days of the date of the grievance resolution letter. Although there was no evidence indicating that members could not file a grievance at any time, the language within the resolution letter should be reevaluated for appropriateness. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
3. A member may file a grievance with the MCO at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §438.228 Contract 7.8.10.6.1; 7.8.10.6.4	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • Three examples of grievances submitted by provider or authorized representative with member written consent **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Page 3 NV Provider Manual, Page 44	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the grievance filing process regarding member consent for when a provider or representative is requesting a grievance on behalf of the member in accordance with federal and Contract requirements. This is further demonstrated in the NV Member Grievance Resolution Policy, Page 3 and the NV Provider Manual, Page 44. There are no examples of grievances filed by a provider on behalf of a member where member gave written consent during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element**.**		
Required Actions: None.		
4. The member may file a grievance either orally or in writing. a. *If a grievance is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt.* 42 CFR §438.402(c)(3)(i) 42 CFR §438.228 Contract 7.8.10.6.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Page 4 NV Member Handbook, Pages 66-67 NV Provider Manual, Page 44	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the grievance filing process regarding grievances filed orally or in writing in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Member Grievance Resolution Policy, Page 4; NV Member		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handbook, Pages 66-67; and the NV Provider Manual, Page 44. The Grievance File Review will also demonstrate the handling of how each grievance was received.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Handling of Grievances		
5. The MCO must acknowledge receipt of each grievance. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**HSAG Recommended Evidence:** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Pages 4 & 7 NV Member Handbook, Page 67 NV Provider Manual, Page 45 NV Member Grievance Acknowledgement 1st Level Letter NV Member Grievance Acknowledgement 2nd Level Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follow the grievance acknowledgement process and timeframes in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Member Grievance Resolution Policy, Pages 4 &7; NV Member Handbook, Page 67; NV Provider Manual, Page 45; NV Member Grievance Acknowledgement 1st Level Letter and NV Member Grievance Acknowledgement 2nd Level Letter. The Grievance File Review will also demonstrate timely acknowledgement of each grievance.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
6. The MCO must ensure that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.2; 7.8.10.10.4.3	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Pages 5 & 7 NV G&A Organizational Chart	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the reviewer and decision processes for all grievances in accordance with federal and Contract requirements. The grievance reviewers and decision processes are further demonstrated in the NV Member Grievance Resolution Policy, Pages 5 & 7 and NV G&A Organizational Chart. The Grievance File Review will also demonstrate appropriate reviewers involved in grievance decisions.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Timely Resolution and Notification of Grievances		
7. The MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. a. The MCO must resolve the grievance and send *written* notice to the affected parties *no later than ninety (90) calendar days* from the day the MCO receives the grievance. b. *The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.*	**HSAG Recommended Evidence:** • Policies and procedures • Grievance resolution notice template • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Pages 3, 5 & 6	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
c. The notice must meet the standards described at 42 CFR §438.10 *and include the results of the resolution process and the date it was completed.* 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract 7.8.10.9.1.1; 7.8.10.11.1	NV Member Grievance 1st Resolution Letter NV Member Grievance 1st Resolution 2nd Level Letter NV Member Grievance 2nd Level Resolution Letter NV Member Grievance No Quality of Care Resolution Letter NV Member Grievance Quality of Care Resolution Letter	
MCO Description of Process: Anthem G&A follows the grievance resolution notice requirements and timeframes for all grievances in accordance with federal and Contract requirements. The grievance resolution processes for all grievances is further demonstrated and communicated in, NV Member Grievance Resolution Policy, Pages 3, 5 & 6; NV Member Grievance 1st Resolution Letter; NV Member Grievance 1st Resolution 2nd Level Letter; NV Member Grievance 2nd Level Resolution Letter; NV Member Grievance No Quality of Care Resolution and NV Member Grievance Quality of Care Resolution Letter. The Grievance File Review will also demonstrate appropriate resolution of each grievance.		
HSAG Findings: All grievances reviewed as part of the case file review were reviewed and notice was sent within 90 calendar days. However, some cases were documented as expedited priority or required a more expeditious review than 90 days but were not completed until months later (e.g., cases 1, 5, 6, and 7). For one case (case 3), the member indicated feeling discriminated against; however, the grievance resolution notice did not explain how MCO staff members investigated the discrimination allegation. Additionally, for most of the case files, there was no evidence to demonstrate that the MCO was also making reasonable efforts to provide oral notice of the resolution of the grievance. Finally, although the grievance resolution letters included a Spanish tagline with appropriate information to meet the intent of 42 CFR §438.10, it was not written in conspicuously visible font. **Recommendations:** Although the MCO indicated it considers the mailing date of the resolution notice as the date the resolution of the grievance is completed, HSAG recommends that the MCO consider adding the date of resolution within the body of the notice. Implementation of this recommendation will be evaluated during future compliance reviews. Additionally, HSAG is also making a recommendation to DHCFP to reduce the current 90-day time frame allowance.		
Required Actions: The MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance, and the written notice must meet the standards described at 42 CFR §438.10 and include the results of the resolution process and the date it was completed.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
8. The MCO may extend the time frame for resolving grievances by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The MCO shows *to the satisfaction of DHCFP* that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract 7.8.10.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frame • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Page 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the grievance resolution notice process regarding member grievance extensions in accordance with federal and Contract requirements. This is further demonstrated in the NV Member Grievance Resolution Policy, Page 6. There are no examples of grievances with extended timeframe during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. However, please see additional related findings under Element 9 of this standard. Of note, the case file review and MCO staff members confirmed that no grievance resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		
9. If the MCO extends the grievance resolution time frame not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of grievances with extended time frames (evidence of DHCFP approval to extend the time frame, oral notice of the extension to the member, written notice of the extension to the member must be included) • Grievance extension template letter • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Page 6	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 7.8.10.9.3		
MCO Description of Process: Anthem G&A follows the grievance resolution notice process regarding health plan requested extensions in accordance with federal and Contract requirements. This process is further demonstrated in the NV Member Grievance Resolution Policy, Page 6. There are no examples of grievances with extended timeframes requiring DHCFP review and approval during the audit review period.		
HSAG Findings: Although the MCO's Member Grievance Resolution–NV policy indicated that grievance time frames may be extended by up to 14 calendar days and that the MCO will notify the member in writing within two calendar days of the reason for the extension and inform the member of the right to file a grievance, the policy did not include that the MCO will make reasonable efforts to give the member prompt oral notice of the delay when a grievance time frame is being extended. **Recommendations:** Although the MCO indicated that there were no examples of grievances with extended time frames during the time period under review, HSAG recommends that the MCO develop a grievance resolution extension notice template with grievance language to ensure the notice is readily available should the MCO ever extend the grievance resolution time frame. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: If the MCO extends the grievance resolution time frame not at the request of the member (after DHCFP approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay, and within two calendar days give members written notice of the reason for the decision to extend the time frame and inform them of the right to file a grievance if they disagree with that decision.		
Appeals General Requirements		
10. The MCO defines an appeal as a review by the MCO of an ABD. 42 CFR §438.400(b) 42 CFR §438.228 Contract 7.8.10.3	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Pages 1 & 2 NV Member Handbook, Pages 82	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Anthem G&A follows the appeal definition in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Pages 1 & 2 and the NV Member Handbook, Page 82.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
11. The MCO may have only one level of appeal for members. 42 CFR §438.402(b) 42 CFR §438.228 Contract 7.8.10.5.2	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the one level appeal review process in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 3.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
12. The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Pages 4 & 7 NV Member Handbook, Pages 69-70 NV Provider Manual, Page 47	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.410(a-b) 42 CFR §438.228 Contract 7.8.10.5.3		
MCO Description of Process: Anthem G&A follows the expedited appeal review process regarding appeal requests received from members and providers for expedited review in accordance with federal and Contract requirements. This process is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Pages 4 & 7, NV Member Handbook, Pages 69-70 and NV Provider Manual, Page 47.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. Following receipt of a notification of an ABD by an MCO, the member has sixty (60) calendar days from the date on the ABD notice in which to file a request for an appeal to the MCO. 42 CFR §438.402(c)(2)(ii) 42 CFR §438.228 Contract 7.8.10.6.3	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 3 NV Member Handbook, section Medical Appeals, Page 68 NV Provider Manual, Page 47 NV Member Provider Initial Denial Upheld Letter NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the ABD resolution notice and timeframe process regarding the notification of an ABD issued by Anthem and the right to request an appeal in accordance with federal and Contract requirements. This process is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 3, NV Member Handbook, section Medical Appeals, Page 68, NV Provider Manual, Page 47, NV Member Provider Initial Denial Upheld and NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If an appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. The MCO must not require the member to submit a written appeal after making an oral appeal.* 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 7.8.10.6.1	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 5 NV Member Handbook, section Medical Appeals, Page 68	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the appeal filing process regarding member consent for when a provider or representative is appealing on behalf of the member in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 5 NV Member Handbook, section Medical Appeals, Page 68. The Appeal File Review will also demonstrate method of appeal receipt handling.		
HSAG Findings: According to the case file review, six of 10 cases did not contain evidence that the MCO obtained members' written consent for a provider or an authorized representative to request an appeal on the member's behalf. Additionally, the Appeal acknowledgement letters inaccurately informed members that the MCO needed a written appeal request within 10 days from the date of the call, and if the information is not received, the appeal would be closed. **Recommendations:** The member handbook indicated that "If you want your PCP or provider to file an appeal for you, he or she must have your written permission, unless you are asking for an expedited appeal." Although this language is in the contract, HSAG strongly recommends that the MCO remove the language stipulating there are exceptions to obtaining written permission as this does not align with federal rule. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must obtain the member's written consent for a provider or an authorized representative to request an appeal on behalf of the member. The MCO must not require the member to submit a written appeal after making an oral appeal.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Appeals		
15. If the MCO denies a request for expedited resolution of an appeal, it must: a. Transfer the appeal to the time frame for standard resolution *of no longer than thirty (30) calendar days from the day the MCO receives the appeal.* b. Follow the requirements in 42 CFR §438.408(c)(2), including: i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.406(b)(1) 42 CFR §438.410(c) 42 CFR §438.228 Contract 7.8.10.5.3	**HSAG Recommended Evidence:** • Policies and procedures • Denied request for an expedited appeal time frame letter template • Three examples of a denied request for an expedited appeal resolution (oral and written notice to the member must be included) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 7 NV Member Handbook, Page 70 NV Member Appeal Expedited to Standard Ack Letter NV Appeal File OS1 Denied for Expedited Resolution, Pages 4, 6 & 49 NV Appeal File 2 Denied for Expedited Resolution, Pages 3, 4 & 22 NV Appeal File 3 Denied for Expedited Resolution, Pages 4, 15 & 31	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the appeal resolution notices and timeframes process for all appeals in accordance with federal and Contract requirements. The appeal resolution notice processes for all appeals are further demonstrated and communicated in NV Medical Necessity Appeals Policy, Page 7; NV Member Handbook, Page 70 and NV Member Appeal Expedited to Standard Ack Letter. **Three examples of a denied request for an expedited appeal resolution:** NV Appeal File OS1 (part of appeal file review), Pages 4, 6 & 49, NV Appeal File 2 Denied for Expedited Resolution, Pages 3, 4 & 22 and NV Appeal File 3 Denied for Expedited Resolution, Pages 4, 15 & 31.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: According to the case file review, the MCO was not making reasonable efforts to give the member prompt oral notice of the delay when the MCO denied a request for expedited resolution of an appeal. Additionally, although two case files did include written notice to the members, the notices did not inform the members of the right to file a grievance if they disagreed with the delay in resolving the appeals.		
Required Actions: If the MCO denies a request for expedited resolution of an appeal, it must make reasonable efforts to give the member prompt oral notice of the delay; and within two calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.		
16. The MCO must acknowledge receipt of each appeal. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**HSAG Recommended Evidence:** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 5 NV Member Appeal Acknowledgement Letter NV G&A Organizational Chart	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the appeal acknowledgement and timeframes process in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 5, NV Member Appeal Acknowledgement Letter and NV G&A Organizational Chart. The Appeal File Review will also demonstrate timely acknowledgement of each appeal.		
HSAG Findings: For all 10 appeals reviewed as part of the case file review, acknowledgement letters were sent within five calendar days as required according to MCO policy. However, for two cases, the acknowledgement letters were addressed to the providers. Members did not receive the acknowledgement letters as required. Additionally, one case was for an expedited appeal, but the acknowledgement letter indicated that the appeal would be resolved in 30 days instead of 72 hours as required. Further, one case was filed by an adult member, but the acknowledgement letter was addressed to "Parent/Guardian of …."		
Required Actions: The MCO must acknowledge receipt of each appeal, and the acknowledgement must be provided to the member.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
17. The MCO must ensure that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.1; 7.8.10.10.4.3	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Pages 4 & 6 NV G&A Organizational Chart	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the appeal reviewer and decision process for all appeals in accordance with federal and Contract requirements. The appeal reviewers and decision processes are further demonstrated in the NV Medical Necessity Appeals Policy, Pages 4 & 6 and NV G&A Organizational Chart. The Appeal File Review will also demonstrate appropriate reviewers involved in appeal decisions.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
18. The MCO must provide that oral inquiries seeking to appeal an ABD are treated as appeals. 42 CFR §438.406(b)(3) 42 CFR §438.228 Contract 7.8.10.10.5	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 5	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows all oral appeal requests in accordance with federal and Contract requirements. The oral appeals request process is further demonstrated in the NV Medical Necessity Appeals Policy, Page 5. The Appeal File Review will also demonstrate oral appeals handling.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
19. The MCO must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.406(b)(4) 42 CFR §438.228 Contract 7.8.10.9.2; 7.8.10.10.6	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 4 NV Member Provider Initial Denial Upheld Letter NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the process to provide members that have requested appeals, information on their case file rights in accordance with federal and Contract requirements. The member case file rights are further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 4, NV Member Provider Initial Denial Upheld Letter and NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
20. The MCO must provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). 42 CFR §438.406(b)(5) 42 CFR §438.228 Contract 7.8.10.10.7	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 4 NV Member Provider Initial Denial Upheld Letter NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the process to provide members that have requested appeals, information on their case file rights in accordance with federal and Contract requirements. The member case file rights are further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 4, NV Member Provider Initial Denial Upheld Letter and NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Resolution and Notification of Appeals		
21. The MCO must resolve standard appeals and send *written* notice to the affected parties as expeditiously as the member's health condition requires, but *no later than thirty (30) calendar days* from the day the MCO receives the appeal. 42 CFR §438.408(a) 42 CFR §438.408(b)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Appeal resolution letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.9.1.2; 7.8.10.11.1	NV Medical Necessity Appeals Policy, Pages 4 & 5 NV Member Appeal Upheld Letter	
MCO Description of Process: Anthem G&A follows the appeal resolution written notice timeframes and process for all appeals in accordance with federal and Contract requirements. The appeal resolution processes are further demonstrated and communicated in, NV Medical Necessity Appeals Policy, Pages 4 & 5 and NV Member Appeal Upheld Letter. The Appeal File Review will also demonstrate timely resolution of each appeal.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
22. The MCO must resolve expedited appeals and send *written* notice to the affected parties no later than seventy-two (72) hours after the MCO receives the appeal. a. *The MCO is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.* 42 CFR §438.408(b)(3) 42 CFR §438.228 Contract 7.8.10.9.1.3; 7.8.10.11.1	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Appeal resolution letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 7 NV Member Appeal Upheld Letter	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the expedited appeal resolution written notice timeframes and process for all appeals in accordance with federal and Contract requirements. The appeal resolution processes is further demonstrated and communicated in NV Medical Necessity Appeals Policy, Page 7 and NV Member Appeal Upheld Letter.		
HSAG Findings: According to the case file review, one expedited appeal case was not resolved within the 72-hour time frame. There was also no evidence to support that the member was notified orally of the decision.		
Required Actions: The MCO must resolve expedited appeals and send written notice to the affected parties no later than 72 hours after the MCO receives the appeal.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
23. The MCO may extend the standard or expedited appeal resolution time frames by up to fourteen (14) calendar days if: a. The member requests the extension; or b. The MCO shows *to the satisfaction of DHCFP* that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract 7.8.10.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended time frames • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the appeal resolution notice timeframes regarding member requested extensions, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 6. There are no examples of appeals with extended timeframes during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that no appeal resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		
24. If the MCO extends the standard or expedited appeal resolution time frames not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of appeals with extended timeframes (evidence of DHCFP approval to extend the time frame, oral notice of the extension to the member, written notice of the extension to the member must be included) • Appeal extension letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 6	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.408(c)(2) 42 CFR §438.228 Contract 7.8.10.9.3		
MCO Description of Process: Anthem G&A follows the appeal resolution notice timeframes and process regarding health plan requested extensions, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 6. There are no examples of appeals with extended timeframes requiring DHCFP review and approval during the audit review period.		
HSAG Findings: Although the NV Medical Necessity Appeals policy indicated time frames may be extended by up to 14 calendar days, and that the MCO will notify the member in writing within two calendar days of the reason for the extension and inform the member of the right to file a grievance, the policy did not include that the MCO will make reasonable efforts to give the member prompt oral notice of the delay when an appeal time frame is being extended. **Recommendations:** Although the MCO indicated that there were no examples of appeals with extended time frames during the time period under review, HSAG recommends that the MCO develop an appeal resolution extension notice template with grievance language to ensure the notice is readily available should the MCO ever extend the appeal resolution time frame. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: If the MCO extends the standard or expedited appeal resolution time frames not at the request of the member (after DHCFP approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay, within two calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision; and resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.		
25. In the case that the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • Three examples of an appeal not resolved timely (written notice to the member must be included) • HSAG will also use the results of the Appeal File Review	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.9.4	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 8 NV Member Handbook, Page 70 NV Provider Manual, Page 49 NV Appeal File 1 Appeal Not Resolved Timely, Pages 1 & 30	
MCO Description of Process: Anthem G&A follows the appeal resolution notice timeframes process regarding appeals not reviewed within the timing requirements, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 8; NV Member Handbook, Page 70 and NV Provider Manual, Page 49. **One example of an appeal not resolved timely:** NV Appeal File 1 Appeal Not Resolved Timely, Pages 1 & 30		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO's NV Member Necessity Appeals policy indicated that if the MCO fails to adhere to the required time frame when resolving the appeal, the member is deemed to have exhausted the MCO's internal appeal process and may request a SFH, HSAG strongly recommends that the MCO develop a process for sending the appeal resolution notice to the member that upholds the previous decision due to untimeliness of decision making and provide the member with SFH rights. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
26. For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request.	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice templates (upheld and overturned) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Pages 6-7 NV Member Appeal Upheld Letter NV Member Appeal Overturn Letter	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
iii. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal. 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228		
MCO Description of Process: Anthem G&A follows the appeal resolution written notices process and next level rights for all upheld appeals, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Pages 6-7, NV Member Appeal Upheld Letter and NV Member Appeal Overturn Letter. The Appeal File Review will also demonstrate appropriate resolution and next level rights.		
HSAG Findings: Although the MCO's policy indicated that the member will always be provided written notification of the appeal determination regardless of who initiates the appeal, according to the case file review findings, one appeal resolution notice was sent to the provider and not to the member. Additionally, although the English tagline was in conspicuous font, the Spanish tagline was not. Although some letters had a bold statement in the beginning of the letter in Spanish indicating, "This letter is about your benefits. If you have questions or need it in Spanish, call…," there was no information on how to request auxiliary aids and services in conspicuous font as required by 42 CFR §438.10. Further, although a tagline sheet was included in the letter, which appears to be in larger font, it only indicated that translation is available at no cost. It did not indicate that other formats are available. Finally, according to the contract with DHCFP currently in effect, the time frame for members to file a SFH is 90 days. For one appeal reviewed as part of the case file review (case 7), the member's denial was upheld; however, the member was not provided with SFH rights. **Recommendations**: The MCO's continuation of benefits language indicated that "if a final decision is made in favor of Anthem, you must pay for all charges during the time of your appeal or fair hearing." HSAG recommends that the MCO consider whether "must" should be updated to "may" if the MCO will not always require the member to pay back the charges for the services obtained during the appeal. Further, as indicated through the case file review, some resolution notices included acronyms that were not spelled out and minor typographical or grammatical errors. As such, HSAG recommends that the MCO ensure it has a quality assurance process to review resolution notices prior to the notices being sent to members. The MCO may also want to consider developing specific template language for appeals that relate to durable medical equipment (DME) to ensure that the template language makes sense with the type of service being appealed. Implementation of these recommendations will be evaluated during future compliance reviews.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution must include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice of resolution must also include the right and how to request a SFH, and the right and how to request and receive benefits while the hearing is pending. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal must also be included.		
27. For notice of a *standard* and expedited appeal resolution, the MCO is *required to make a good faith effort* to provide oral notice *of the disposition in addition to the required written notice*. 42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 7.8.10.11.1	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of oral notice for an expedited appeal resolution • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 74 NV Appeal File Review 6 Oral Notice for Expedited Resolution, Page 74 NV Appeal File 2 Oral Notice for Expedited Resolution, Pages 1, 4 & 22 NV Appeal File 3 Oral Notice for Expedited Resolution, Pages 1, 5 & 23	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the expedited appeal resolution notice timeframes, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 74. **Three examples of oral notice for an expedited appeal resolution:** NV Appeal File Review 6 Oral Notice for Expedited Resolution, Page 7 (part of appeal file review), NV Appeal File 2 Oral Notice for Expedited Resolution, Pages 1, 4 & 22 and NV Appeal File 3 Oral Notice for Expedited Resolution, Pages 1, 5 & 23.		
HSAG Findings: The results of the case file review indicated that the MCO was not making a good faith effort to provide members with oral notice of the appeal resolution.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: For notice of a standard and expedited appeal resolution, the MCO must make a good faith effort to provide oral notice of the disposition in addition to the required written notice.		
State Fair Hearings		
28. The member may request a SFH only after receiving notice that the MCO is upholding the ABD related to the appeal. 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract 7.8.10.6.2; 7.8.10.12.1	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 8 NV Member Appeal Upheld Letter NV Member Handbook, Page 70	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the SFH uphold timeframes, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 8, NV Member Appeal Upheld Letter and NV Member Handbook, Page 70.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
29. *The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the MCO's notice of resolution of the appeal.* a. *The MCO is required to inform the member of their right to a SFH, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO*	**HSAG Recommended Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 8	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
pursuant to 42 CFR §431.200(b); 42 CFR §431.220(a)(6) and 42 CFR §438.408(e)(2)(i). 42 CFR §438.408(f)(2) 42 CFR §438.228 Contract 7.8.10.12.1; 7.8.10.12.2	NV Member Handbook, Page 70 NV Member Provider Initial Denial Upheld Letter NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter	
MCO Description of Process: Anthem G&A follows the SFH uphold timeframes and notification of member rights to a SFH, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 8, NV Member Handbook, Page 70, NV Member Provider Initial Denial Upheld Letter and NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter.		
HSAG Findings: The case file review indicated that members were notified that they must request SFH rights within 120 days of the appeal notice, and not 90 days as required by the current MCO/DHCFP contract. The member handbook and Medical Necessity Appeals – NV policy also inaccurately indicated the member has 120 calendar days from the date of the appeal denial letter to file a SFH. In follow-up to the site review, the MCO indicated that the state fiscal year (SFY) 2019 compliance review tool included 120 days for members to file a SFH. Please note that this time frame aligned with the final Medicaid managed care rule published May 6, 2016 (refer to https://www.law.cornell.edu/rio/citation/81_FR_27853), during this time period under review. However, the final Medicaid managed care rule was amended on November 13, 2020, and the time frame for requesting a SFH was updated to allow states to stipulate hearing time frames to "no less than 90 calendar days and no greater than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution." According to the federal register at https://www.law.cornell.edu/rio/citation/85_FR_72842: **Resolution and Notification: Grievances and Appeals (§ 438.408)** We proposed a revision to § 438.408(f)(2) to require the timeframe for an enrollee to request a state fair hearing after receiving an adverse decision from a managed care plan would be no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution; under this proposal, the state would set the specific deadline within these limits. Previously, in the 2016 final rule, we revised the timeframe for managed care enrollees to request a state fair hearing to 120 calendar days from a plan's decision; this was codified at § 438.408(f)(2). We adopted this timeframe because we believed it would give enrollees more time to gather the necessary information, seek assistance for the state fair hearing process, and make the request for a state fair hearing (81 FR 27516). However, we have heard from stakeholders that the 120-calendar day requirement has created an inconsistency in filing timeframes between Medicaid FFS and managed care, creating administrative burdens for states and confusion for enrollees. The FFS rule limits the timeframe beneficiaries have to request a hearing to no more than 90 days		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
(§ 431.221(d)). It was not our intent to burden states with additional tracking of the fair hearing process in multiple systems, on multiple timeframes. Nor do we want to confuse enrollees in states where some services are provided through FFS and others through managed care. Therefore, we proposed to revise § 438.408(f)(2) to stipulate that the timeframe for enrollees to request a state fair hearing will be no less than 90 calendar days and no greater than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution. We stated the proposed revision would allow states that wished to align managed care with the FFS filing timeframe to do so without jeopardizing the enrollee's ability to gather information and prepare for a state hearing. This proposal would also allow states that have already implemented the 120-calendar day timeframe to maintain that timeframe without the need for additional changes. Although RFP 3260 (historical contract) originally indicated that members had 90 days to file a SFH, RFP 3260 was later amended to comply with the 120 days required under federal regulations. However, with the allowance under the 2020 final Medicaid managed care rule, DHCFP updated language within RFP S1457 (contract effective during the review period) to 90 days to coincide with the revised allowances under federal rule for SFH time frame requirements. The MCO must ensure that it reviews each version of its contract with DHCFP and make timely updates to policies, procedures, and member materials to accurately reflect all contract revisions.		
Required Actions: The MCO must ensure that the member submits a request for a SFH in writing within 90 calendar days from the date of the MCO's notice of resolution of the appeal. The MCO is required to inform the member of the right to a SFH, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO pursuant to 42 CFR §431.200(b), 42 CFR §431.220(a)(6), and 42 CFR §438.408(e)(2)(i).		
Continuation of Benefits		
30. The MCO must continue the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider.	**HSAG Recommended Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • Three examples of member requests for continuation of member benefits **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. *Timely files* means on or before the later of the following: within ten (10) calendar days of the MCO sending the notice of ABD, or the intended effective date of the MCO's proposed ABD. 42 CFR §438.420 (a-b) 42 CFR §438.228 Contract 7.8.10.8.1; 7.8.10.8.1.1-7.8.10.8.1.6	NV Medical Necessity Appeals Policy, Page 8 NV Member Provider Initial Denial Upheld Letter NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter NV Member Appeal Upheld Letter NV Request to Continue Benefits during an Appeal or a Fair Hearing Form NV State Fair Hearing Form	
MCO Description of Process: Anthem G&A follows the continuation of benefits timeframes and notification to members, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 8, NV Member Provider Initial Denial Upheld Letter, NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter and NV Member Appeal Upheld Letter.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
31. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs: a. The member withdraws the appeal or request for SFH. b. The member fails to request a SFH and continuation of benefits within ten (10) calendar days after the MCO sends the notice of an adverse resolution to the member's appeal. c. A SFH office issues a hearing decision adverse to the member. 42 CFR §438.420 (c) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of documentation related to continuation of member benefits **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 8	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract 7.8.10.8.2; 7.8.10.8.2.1-7.8.10.8.2.3		
MCO Description of Process: Anthem G&A follows the continuation and reinstatement of member benefits timeframes and the notification to members, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 8. There is no example of a continuation of benefits request during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
32. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCO's ABD, the MCO may recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR §431.230(b). 42 CFR §438.420 (d) 42 CFR §438.228 Contract 7.8.10.8.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of cost recovery **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 8	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows resolution decisions regarding SFH, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 8. There is no example of a cost recovery during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
33. If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of reinstatement of services (the date of the reversal and date the services were reinstated must be included)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.424(a) 42 CFR §438.228 Contract 7.8.10.8.4	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 9	
MCO Description of Process: Anthem G&A follows all reversal decisions regarding SFH, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 9. There are no examples of reinstatement of services during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
34. If the MCO or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, *the MCO must pay for those services.* 42 CFR §438.424(b) 42 CFR §438.228 Contract 7.8.10.8.4	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of a SFH reversal with corresponding authorization of services **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 9	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows all reversal decisions regarding SFH, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 9. There are no examples of a SFH reversal with corresponding authorization of services during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievances, Appeals, and State Fair Hearings		
35. In handling grievances and appeals, the MCO must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate teletypewriter (TTY)/telecommunications device for the deaf (TTD) and interpreter capability. a. *The MCO must assist the member and/or the member's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing.* 42 CFR §438.406(a) 42 CFR §438.228 Contract 7.8.10.10.1	**HSAG Recommended Evidence:** • Policies and procedures • Member handbook(s) • One example of assistance to members in filing a grievance and appeal **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 1 NV Member Grievance Resolution Policy, Page 3 NV Member Handbook, Pages 8, 51 & 95 Agent Assisted Grievance (Screen Capture)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the handling of grievances and appeals for when a member needs assistance, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 1, NV Member Grievance Resolution Policy, Page 3, and NV Member Handbook, Pages 8, 51 & 95. The Appeal and Grievance File Reviews will also demonstrate evidence of assistance, if applicable.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
36. The MCO must provide information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.	**HSAG Recommended Evidence:** • Policies and procedures • Provider manual • Provider contract template	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.414 42 CFR §438.228 Contract 7.8.10.4; 7.8.10.4.1-7.8.10.4.5	• Subcontractor agreement template **Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Pages 2 & 3 NV Provider Manual, Pg 45 - 49 Anthem Sample Provider Agreement_NV Provider Contract Anthem Master Services Agreement_NV Subcontractor Agreement	
MCO Description of Process: Anthem provides information about the grievance and appeal system in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Member Grievance Resolution Policy, Pages 2 & 3, Provider Manual, Anthem Sample Provider Agreement_NV Provider Contract and Anthem Master Services Agreement_NV Subcontractor Agreement.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO update the provider manual to remove/update the statements, "However, you do not need prior written authorization from the member if you or the member are making an expedited appeal on behalf of the member," and "You may ask for a State Fair Hearing within 120 calendar days from the date of the appeal denial letter saying we denied coverage of services" as these statements are inaccurate. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
37. The MCO must include as parties to the appeal and SFH: a. The member and his or her representative b. The legal representative of a deceased member's estate c. *The MCO will participate in the SFH process, at the MCO's expense, in each circumstance in which a member for whom the MCO has made an ABD requests a SFH. The MCO is bound by the decision of the Fair Hearing Officer.* 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §438.228	**HSAG Recommended Evidence:** • Policies and procedures • Evidence of SFH participation **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Pages 4 & 9	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Contract 7.8.10.10.8; 7.8.10.12.3		
MCO Description of Process: Anthem G&A includes all appropriate SFH parties and follows the SFH decision terms in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Pages 4 & 9. There are no SFH cases to demonstrate SFH participation during the audit review period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Recordkeeping Requirements		
38. Grievance and appeal records must be accurately maintained *for a period of no less than ten (10) years* in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. 42 CFR § 438.416(b-c) 42 CFR §438.228 Contract 7.8.10.5.7	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals and Grievances File Reviews **Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 9 NV Member Grievance Resolution Policy, Pages 4 & 8	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem G&A follows the handling and tracking of grievances and appeals records timeframes in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 9 and NV Member Grievance Resolution		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Policy, Pages 4 & 8. The Appeal and Grievance File Reviews will also demonstrate evidence of grievance and appeal records and all of the information documented in the G&A tracking system.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems						
Met	=	28	X	1	=	28
Not Met	=	10	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	38	**Total Score**		=	28
Total Score ÷ Total Applicable					=	74%

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCO may have with any delegate, MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. a. *The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.* b. *The MCO must submit all subcontractors to DHCFP for advance written approval prior to the subcontractor's effective date.* c. *Within thirty-five (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 a business transaction totaling more than twenty-five thousand dollars ($25,000) during the twelve-month (12-month) period ending on the date of request as required by 42 CFR §455.105* 42 CFR §438.230(b)(1) Contract 7.2.2.1; 7.2.2.2; 7.2.2.3; 7.2.2.4	**HSAG Recommended Evidence:** • Policies and procedures • Pre-delegation assessment (for delegates implemented within the past fiscal year) • Written approval from DHCFP (for delegates implemented within the past fiscal year) • Example of completed request for ownership information • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCO:** Policies and Procedures: • Procurement Policy – Pgs 3 & 11 • Subcontractor Due Diligence – Pgs 2,4,5-7 • Delegate Vendor Oversight and Management Program – Pg 2, Pg 11-14 Sec V-VI Written approvals from DHCFP: • Chess Health Approval • Quest HealthConnect Approval • Truth Initiative This is Quitting Approval Example of completed request for ownership: • Truth Initiative Disclosure Of Ownership • Truth Initiative Subcontractor Checklist Delegation agreement/contract template:	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• Elevance Health (fka Anthem) Master Services Agreement	
MCO Description of Process: Anthem oversees, and is accountable for, any functions and responsibilities that it delegates to any subcontractor. This is detailed further in the Delegate Vendor Oversight and Management Program. Also, Anthem would like to advise that we have not received any requests from DHCFP for disclosure of ownership within the look back period of this audit. Additionally, there were no pre-delegation audits within the past fiscal year due to the approvals being for subcontracts that are not delegated contract functions but instead value added services.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, MCO staff members indicated that the MCO has not received a request from DHCFP for the information described in sub-element (c). **Recommendations:** While the Nevada Subcontractor Checklist Template included the following question, "What is the vendor's ownership interest in the subcontractor?", the MCO's documentation cited as evidence of compliance for this element did not specifically include the reporting requirement of sub-element (c). As such, HSAG recommends that the MCO add the provision of sub-element (c) to a policy, procedure, or workflow to ensure staff awareness of this reporting standard. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO determine that the delegate has not performed satisfactorily.	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • a.NV Subcontractor Exhibit, Attachment 1, Section (m), Pg 9 • b.NV Subcontractor Exhibit, Section 15, Pg 7 • c.NV Subcontractor Exhibit, Section 5(f), Pg 3	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) Contract 7.2.2.5		
MCO Description of Process: Anthem maintains subcontracts and delegation agreements in writing. Templates of these agreements are provided to support this requirement.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** As the federal managed care rule specifically requires all delegated written arrangements to include reporting responsibilities, HSAG recommends that the MCO enhance processes to ensure its written arrangements with all delegates clearly identify all reporting requirements and are catered towards each delegate's specific scope services for Nevada Medicaid. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, *including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention.* 42 CFR §438.230(c)(2) Contract 7.2.2.7	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • NV Subcontractor Exhibit, Section 1, Pg 1 • NV Subcontractor Exhibit, Attachment 1, Section (g), Pg 8	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem maintains subcontracts and delegation agreements in writing. Templates of these agreements are provided to support this requirement.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3)(i-iv)	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • a.NV Subcontractor Exhibit, Section 5(a), Pg 2 • b.NV Subcontractor Exhibit, Section 5(a), Pg 2 • c.NV Subcontractor Exhibit, Section 5(b), Pg 3 • d.NV Subcontractor Exhibit, Section 5(b) (iii), Pg 3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem maintains subcontracts and delegation agreements in writing. Templates of these agreements are provided to support this requirement.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Monitoring and Auditing		
5. *The MCO is responsible for oversight of all subcontracts and is accountable for any responsibilities it delegates to any subcontractor.* a. *The MCO must monitor the subcontractor's performance on an on-going basis.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of consecutive reporting • Three examples of consecutive delegation oversight committee meeting minutes • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** Delegation agreement/contract template: • Elevance Health (fka Anthem) Master Services Agreement, Sec 4.4.2, Pg 8, Sec 5.1, Pg 14 • Elevance Health (fka Anthem) Vision SOW Template, Sec 1.2, Pg 17 • Delegate Vendor Oversight and Management Program Sec VII Pg 14-15, Sec B-D Pgs 16-18 Examples of consecutive reporting: • Anthem BCBS-2022-02 (Feb)-Reporting Package • Anthem BCBS-2022-03 (Mar)-Reporting Package • Anthem BCBS-2022-04 (Apr)-Reporting Package Committee meeting minutes: • Approved Enterprise DOC Meeting Minutes (03232022)_Redacted • Approved Enterprise DOC Meeting Minutes (04272022)_Redacted	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• Approved Enterprise DOC Meeting Minutes (05252022)_Redacted	
MCO Description of Process: Anthem monitors subcontractors' data, data submission and performance through the annual audit process and through the review of reporting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The Enterprise Delegation Operations Committee meeting minutes were very high level, and it was unclear what was reviewed related to the MCO's oversight of delegates for Nevada Medicaid. As such, HSAG recommends that the MCO enhance processes to ensure meaningful meeting minutes are maintained. Additionally, to further demonstrate compliance, the MCO should submit any supporting documentation to these meetings (e.g., reports that are presented) during future compliance reviews. Further, HSAG requested a semiannual report for one of its delegates. However, after the site review, the MCO explained that it had requested the credentialing report but did not receive it in time for the submission due date for the information, and subsequently provided the report after the due date. As such, HSAG strongly recommends that the MCO gather examples of report deliverables as part of its desk review submission during future compliance reviews. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
6. *The MCO conducts a formal review of the subcontractor according to a periodic schedule established by the State, consistent with industry standards, and/or State laws and regulations.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of formal review results • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** Delegation agreement/contract template: • Elevance Health (fka Anthem) Master Services Agreement Sec 4.4.2, Pg 8 • Elevance Health (fka Anthem) Vision SOW Template, Sec 1.2, Pg 17 Examples of formal review results: • EyeQuest 2022 UM AA	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• EyeQuest 2022 Cred AA • AIM 2021 UM AA • AIM 2021 GL AA	
MCO Description of Process: Anthem monitors subcontractors' data, data submission and performance through the annual audit process and through the review of reporting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. *If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of corrective action plans • Committee meeting minutes • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** Delegation agreement/contract template: • Elevance Health (fka Anthem) Master Services Agreement Sec 4.4.3, Pg 8 • Elevance Health (fka Anthem) Vision SOW Template, Sec 2.7, Pg 22 Corrective action plan example: • AIM 2021 UM CAP Committee meeting minutes: • Approved Enterprise DOC Meeting Minutes (03232022)_Redacted	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• Approved Enterprise DOC Meeting Minutes (04272022)_Redacted • Approved Enterprise DOC Meeting Minutes (05252022)_Redacted	
MCO Description of Process: Anthem monitors subcontractors' performance through the annual audit process. Three examples of corrective action plans do not currently exist for the look back period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	**Total Score**		=	7
Total Score ÷ Total Applicable					=	100%

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. *The MCO's Chief Medical Director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.* Contract 7.2.1.6.2.3	**HSAG Recommended Evidence:** • Job description • Committee charter • Committee meeting minutes **Evidence as Submitted by the MCO:** 2022 Utilization Management Program Description, Pg 10 Anthem Medical Director Job Description GBD UM 013 Medical Operations Committee, Pgs 1-2 Clinical Services Committee Charter 2022 Medical Advisory Committee Charter 2022 Quality Management Committee Charter Medical Operations Committee Meeting Minutes: - MOC Minutes January 27, 2022 - MOC Minutes February 24, 2022 - MCO Minutes March 24, 2022 - MOC Minutes April 28, 2022 - MOC Minutes May 26, 2022 Clinical Services Committee Meeting Minutes_3.2022 Medical Advisory Committee Meeting Minutes_3.2022 Quality Management Committee Meeting Minutes_3.2022	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Our Chief Medical Director oversees all medical care for members served in Nevada, including medical leadership and principal medical advisor for executive leadership. The Chief Medical Director is licensed in the State of Nevada and in collaboration with Clinical Health Plan leadership, is directly responsible for the supervision, oversight, and evaluation of the Utilization Management program, as well as review and creation of clinical and policy decisions. The Chief Medical Director is also responsible for the oversight of the Internal Quality Assurance Program while serving on Clinical Policy and Health Plan committee, including clinical standards of care and practice guidelines. The Chief Medical Director aligns with the scope as outlined in section 7.2.1.6. of contract S1457.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. The MCO must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236 (b)(1) Contract 7.6.12.1; 7.6.12.1.1	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** HCM 012 Precertification Committee, Pgs 1-3, 4 sec 15 & 16 UM 013 Medical Operations Committee, Pgs 1-2 Policy Clinical Practice Guidelines NV Medicaid Clinical Practice Guidelines Clinical Practice Guidelines Link ASAM InterQual: InterQual Guidelines MCG:MCG Guidelines Coverage of Services throughout NV MSM: MSMHome (nv.gov) **Website:** Provider manuals and guides | Anthem Blue Cross and Blue Shield Healthcare Solutions	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	Website Provider Medical Policy Search Results | Anthem.com 2022 Utilization Management Program Description, Pg 6-8, 11-12 NVProviderManual1**,** Pgs 73, 75-81, 84, 86 May 2022 Provider Bulletin Clinical Guidelines Medical Operations Committee Meeting Minutes: - MOC Minutes January 27, 2022 - MOC Minutes February 24, 2022 - MCO Minutes March 24, 2022 - MOC Minutes April 28, 2022 - MOC Minutes May 26, 2022 Clinical Services Committee Meeting Minutes_3.2022 Medical Advisory Committee Meeting Minutes_3.2022 Quality Management Committee Meeting Minutes_3.2022	
MCO Description of Process: Anthem utilizes the most up-to-date clinical practice guidelines for authorization determination and assistance in Member plan of care with their providers. Clinical Services is the Health Plan committee, consisting of internal leadership, which review best practices, trends, and review or creation of policies and procedures or guidelines. From there, policies, procedures, and guidelines are reviewed in both Quality Management Committee and Medical Advisory Committee, both of which consist of internal clinical leadership and external network providers. All policies and Guidelines are ultimately reviewed in the Medical Operation Committee for approval. All practice guidelines are reviewed at least yearly, with off cycle edits as warranted by oversight agencies such as the Nevada MSM, Centers for Disease, and so on.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
3. The MCO must adopt practice guidelines that consider the needs of the MCO's members. 42 CFR §438.236 (b)(2) Contract 7.6.12.1.2	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** Policy Clinical Practice Guidelines NV Medicaid Clinical Practice Guidelines NV_CAID_CPGMatrix.pdf (anthem.com) NV ProviderManual1, Pgs 73, 75-81, 84, 86 Website: Patient care | Anthem Blue Cross and Blue Shield Healthcare Solutions Website: https://providers.anthem.com/nevada-provider/resources/manuals-and-guides Member Handbook, Pgs 12-40, 46, 63, 66-70, 77-78 Medical Operations Committee Meeting Minutes: - MOC Minutes January 27, 2022 - MOC Minutes February 24, 2022 - MCO Minutes March 24, 2022 - MOC Minutes April 28, 2022 - MOC Minutes May 26, 2022 Clinical Services Committee Meeting Minutes_3.2022 Medical Advisory Committee Meeting Minutes_3.2022 Quality Management Committee Meeting Minutes_3.2022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. The MCO must adopt practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236 (b)(3) Contract 7.6.12.1.3	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval • Evidence of consultation of network providers	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the MCO: Policy Clinical Practice Guidelines NV Medicaid Clinical Practice Guidelines NV_CAID_CPGMatrix.pdf (anthem.com) 2022 Utilization Management Program Description, Pg 7 NV ProviderManual1, Pages 73, 75-81, 84, 86 May 2022 Provider Bulletin Clinical Guidelines Website: Patient care | Anthem Blue Cross and Blue Shield Healthcare Solutions Website: https://providers.anthem.com/nevada-provider/resources/manuals-and-guides 2022 Medical Advisory Committee Charter 2022 Quality Management Committee Charter Medical Advisory Committee Meeting Minutes_3.2022 Quality Management Committee Meeting Minutes_3.2022	

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	2022 1st qtr CAC meeting minutes	
MCO Description of Process: Anthem welcomes and encourages participation from our network providers in review, oversight, and creation of practice guidelines, as indicated in an invitation sent to our providers via our Anthem Provider Manual. Providers are encouraged to participate in our Quality Management Committee and Medical Advisory Committee, in which they also have voting privileges to approve or deny policies and guidelines being reviewed.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
5. The MCO must adopt practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236 (b)(4) Contract 7.6.12.1.4	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** HCM 012 Precertification Committee UM 013 Medical Operations Committee Policy Clinical Practice Guidelines NV Medicaid Clinical Practice Guidelines NV_CAID_CPGMatrix.pdf (anthem.com) ASAM InterQual: InterQual Guidelines MCG:MCG Guidelines Coverage of Services throughout NV MSM: MSMHome (nv.gov) Website: Patient care | Anthem Blue Cross and Blue Shield Healthcare Solutions Website: https://providers.anthem.com/nevada-provider/resources/manuals-and-guides	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	2022 Utilization Management Program Description, Pg 6-8, 11-12 NV ProviderManual1, Pgs 73, 75-81, 84, 86 May 2022 Provider Bulletin Clinical Guidelines Medical Operations Committee Meeting Minutes: - MOC Minutes January 27, 2022 - MOC Minutes February 24, 2022 - MCO Minutes March 24, 2022 - MOC Minutes April 28, 2022 - MOC Minutes May 26, 2022 Clinical Services Committee Meeting Minutes_3.2022 Medical Advisory Committee Meeting Minutes_3.2022 Quality Management Committee Meeting Minutes_3.2022	
MCO Description of Process: Anthem continuously reviews Evidence Based Practice and Practice Guidelines to ensure our staff and providers are utilizing the most up-to-date practice available, updating our internal policies and procedures accordingly. Internal policies and procedures are updated at least yearly, or when an off-cycle review is needed, with the Medical Operations Committee formally reviewing and approving policies with internal leadership after approval from the Quality Management Committee and Medical Advisory Committee, including external network provider consultation. Clinical Guidelines are reviewed annually and a Provider Bulletin is distributed to all network providers with notification.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. *The MCO must adopt practice guidelines that comply with requirements for parity in mental health and substance use disorder benefits in accordance with 42 CFR §438.910(d).*	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Utilization review program description • Meeting minutes documenting committee review/approval	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
a. *The MCO's prior authorization requirements are documented and applied in a manner that comply with the guidelines for parity in mental health and substance use disorder.* Contract 7.6.12.1.5	• Prior authorization criteria for mental health/substance use disorder treatment **Evidence as Submitted by the MCO:** Behavioral Health Parity, Pages 1-2, 5 GBD UM 017 Precertification Core Process, Pgs 1-4, 37 GBD UM 008 Health Care Management Denial – Core Process, Pgs 1-19, 41-42 GBD UM 013 Medical Operations Committee, Pgs 1-2, & review/updates shown in pages 4-5 HCM 012 Precertification Committee, Entire Policy Policy Clinical Practice Guidelines NV Medicaid Clinical Practice Guidelines NV_CAID_CPGMatrix.pdf (anthem.com) 1.4.22 Recipient Access NQTL 1.4.22 Authorization Criteria NQTL 1.4.22 Facility Access NQTL 1.4.22 Provider Access NQTL Member Handbook, Pgs 12-13 Medical Advisory Committee Meeting Minutes_3.2022 Quality Management Committee Meeting Minutes_3.2022 2022 Utilization Management Program Description, Pgs 11-12, 30	
MCO Description of Process: Anthem ensures that our health plan provides benefits for mental health and substance use disorders at levels comparable to benefits we provide for medical or surgical services. Specifically, we ensure that financial requirements and treatment limitations for behavioral health		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
services are not more restrictive than those for medical/surgical services. Anthem ensures that covered services are evaluated and are medically necessary, whether they are medical/surgical or behavioral health services. "Medically necessary" services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a practitioner, exercising prudent clinical judgment, would provide to a covered individual to prevent, evaluate, diagnose or treat an illness, injury or disease or its symptoms. We utilize well established Medical Necessity tools for our behavioral health services including MCG and ASAM criteria.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Dissemination of Guidelines		
7. The MCO disseminates the guidelines, *including prior authorization policies and procedures*, to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236 (c) Contract 7.6.12.2	**HSAG Recommended Evidence:** • Policies and procedures • Utilization review program description • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCO:** GBD UM 017 Precertification Core Process**,** Pgs 1-2, 4-8 37-40 GBD UM 008 Health Care Management Denial – Core Process, Pgs 7-9, 12-1, 41-42 **Provider Resources:** Website: Patient care | Anthem Blue Cross and Blue Shield Healthcare Solutions Website: https://providers.anthem.com/nevada-provider/resources/manuals-and-guides	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	2022 Utilization Management Program Description, Pgs 12, 23-24, 26-27 Member Handbook , Pages 11-13, 13-40, 46 Provider Manual, Pages 17-28, 61, 77-81, 103, 115-116	
MCO Description of Process: Anthem disseminates practice guidelines to all affected Providers and Members, including prior authorization policies and procedures through a variety of methods such as the Member Handbook and Provider Manual, available in print and online via Anthem NV Medicaid website and provider portal. All Adverse Benefit Denial notices to Providers and Members also include guidelines utilized to render the determination as well as Anthem contact information and Member Rights regarding appeals, grievances, and questions or concerns. Providers are also provided resources to view Anthem and Clinical Practice Guidelines via the Anthem Provider website, in addition to, participating in oversight and creation of new policies and guidelines in the Quality Management Committee and Medical Advisory Committee. Members and Providers can contact Anthem for any questions, concerns, or requests to view guidelines utilized to render authorization determinations.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Application of Guidelines		
8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236 (d) Contract 7.6.12.3	**HSAG Recommended Evidence:** • Policies and procedures • Coverage guidelines/criteria • Utilization review program description • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices **Evidence as Submitted by the MCO** New Baby, New Life Resource Guide nvnv_caid_preventivehealthguidelines_eng	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	GBD UM 017 Precertification Core Process**,** Pgs 2-7, 37-40 GBD UM 127 Continuity of Care Core Process, Pgs 1-5 GBD UM 008 Health Care Management Denial – Core Process, Entire Policy Coverage of Services throughout NV MSM: MSMHome (nv.gov) Policy Clinical Practice Guidelines NV Medicaid Clinical Practice Guidelines NV_CAID_CPGMatrix.pdf (anthem.com) ASAM InterQual: InterQual Guidelines MCG:MCG Guidelines 2022 Utilization Management Program Description Pgs 6-8, 12-21, 26-28 CareManagementProgram Description 2022, Healthwise Pages 6, 17, 45-46 Member handbook, Pgs 12-13, 13-40, 46, 63, 66-70, 77-78 12 2021 Member Provider Initial Denial Letter Template UM Denial Sample 1 UM Denial Sample 2 UM Denial Sample 3	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
9. *Network providers are required to use designated practice guidelines and protocols.* Contract 7.6.12.4	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as provider manual • Provider contract template • Utilization review program description **Evidence as Submitted by the MCO:** NV ProviderManual, Pgs 73, 84, 86 2022 Utilization Management Program Description Pg 7 Anthem Sample Provider Agreement, Pg 4 Sec 2.9	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. *The MCO offers feedback to individual network providers on adherence to evidence-based practice guidelines and positive and negative care variances from standard clinical pathways that may impact outcomes or costs.* a. *The MCO uses this information to guide activities, such as performance improvement projects for network providers.* Contract 7.6.9	**HSAG Recommended Evidence:** • Policies and procedures • Utilization review program description • Three examples of provider education re: adherence to practice guidelines • Analyses of information, and documentation of follow-up activities **Evidence as Submitted by the MCO:** 2022 Utilization Management Program Description, Pgs 7, 12 Anthem Sample Provider Agreement Website: Patient care | Anthem Blue Cross and Blue Shield Healthcare Solutions	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	Website: https://providers.anthem.com/nevada-provider/resources/manuals-and-guides Anthem Module 4 PIPs.zip May 2022 Provider Bulletin Clinical Guidelines	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines						
Met	=	10	X	1	=	10
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	10	Total Score		=	10
Total Score ÷ Total Applicable					=	100%

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems must provide information on areas including, but not limited to: a. Utilization b. Claims payment c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility e. *Enrollment* f. *Eligibility* g. *Provider network data* h. *Encounter data* i. *Electronic Visit Verification (EVV)* 42 CFR §438.242(a) Contract 7.12.2.1; 7.12.2.2; 7.12.4.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current Information Systems Capabilities Assessment (ISCA) • Technical manual(s) • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** 1. XIII.1 – Anthem_GBD_MIS_v2.10.docx Citation – Entire Document **a. Utilization** XIII.1.a_Facets v5.8 Utilization Management Import Subsystem Guide.pdf XIII.1.a_Facets_UM_Processing_User_Guide_5_504 OT12.pdf XIII.1.a_Facets_UM_Processing_User_Guide_5_804 OT12.pdf **b. Claims payment** XIII.1.b_Claims_Process.pdf **c. Grievances and appeals** XIII.1.C_Administrative Denial Appeal Process.docx XIII.1.C_Medical necessity Appeals.docx XIII.1.C_Member Grievance Resolution.docx **d. Disenrollments for other than loss of Medicaid Eligibility**	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	XIII.1.D_Member Request for Disenrollment.docx XIII.1.D_AGP Pega System.docx XIII.1.D_Enrollment Termination Examples.docx **e. Enrollment** XIII.1.e_Membership Load – Facets XIII.1.E_Primary Care Provider Selection, Assignment and Change Requests - NV XIII.1.E_Pregnant Women and Newborn Enrollment – NV **f. Eligibility** XIII.1.F_GBD Member Management IT Overview Masterv2021.3.0.pdf **g. Provider Network Management** XIII.1_Anthem_GBD_MIS_v2.1.pdf Citation: Provider - Pages 18 & 19 **h. Encounter Data** XIII.1_Anthem_GBD_MIS_v2.1 Citation: Encounters - Pages 12 & 13	
MCO Description of Process: Anthem/Elevance supports Managed Care contracts with a fully integrated Management Information System (MIS) design. At the center of the design are five key integrated components: 1) Core Service Platform; 2) Health Intech Platform; 3) Data Warehouse; 4) Sydney Health; and 5) Provider Websites. The Core Service Platform is the system of record for member, provider, authorization and claims data. The Health Intech Platform is the source for member clinical and care coordination processes and data. The Data Warehouse serves as an integrated data repository for operations, analytics and reporting. Sydney Health provides a public and secure self-service digital experience for members. The Provider Websites provides a public and secure self-service digital experience to providers. Together, the components effectively support all aspects of managed care. From an end-to-end perspective, credentialed providers, membership/eligibility, and contract benefits are loaded/configured in the Core Service Platform. This framework of information supports service authorizations, claims processing and encounters. The Health Intech Platform relies on this framework of information to support the care coordination, utilization management, case management and disease management for members. Supplemental applications		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
support quality, grievance and appeals processes and other tasks necessary to support member and provider functions. The Data Warehouse serves as a repository for all functional data used within the Core Service Platform and Health Intech Platform. The Data Warehouse supports regulatory, contractual and operational reporting and provides the information required for data extract files sent to vendors and partners supporting each market. The Anthem_GBD_MIS document provides additional details regarding the integrated design used by Anthem/Elevance to support managed care contractual requirements.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Basic Elements of a Health Information System		
2. The MCO must comply with section 6504(a) of the Affordable Care Act, and ensure its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHCFP to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) Contract 7.7.1.3	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 a. Citation: Claims - Pages 10 & 11 b. Citation: Encounters - Pages 12 & 13 XIII.2_Alterations to Claims and Encounters XIII.2_Encounter Submission – NV.docx	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem performs claims processing as outlined in Anthem_GBD_MIS_v2.1.pdf. All claim types are accepted via paper or electronically from In-network and Out-of-Network providers and processed based on member eligibility and benefits plans. Claims are adjudicated and provider explanation of payment / actual payment is sent to the provider as per their requested method – e.g. check or electronic payment.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
3. The MCO shall comply with the following: a. The MCO must collect data on member and provider characteristics as specified by DHCFP and on all services furnished to members through an encounter data system or other method as may be specified by DHCFP. 42 CFR §438.242(b)(2) Contract 7.12.4.1.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 a. Citation: MIS Overview / Core Service Platform - Pages 5 & 6 b. Citation: Enrollment - Pages 8 & 9 c. Citation: Claims – Pages 10 & 11 d. Citation: Encounters - Pages 12 & 13 e. Citation: Provider – Pages 18 & 19	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem_GBD_MIS document illustrates information systems/functions currently used to load member and provider data, process claims and report encounters to the State.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. The MCO must ensure that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCO is compensating on the basis of capitation payments.	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) Contract 7.12.4.1.2-7.12.4.1.3	• Claim timeliness reports HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 a. Citation: Claims - Pages 10 & 11 b. Citation: Care Coordination & Care Management – Pages 14 & 15 c. Citation: Provider - Pages 18 & 19 d. Citation: Reporting - Pages 24 & 25 e. Citation: Data Exchanges – Pages 33 & 34 2. XIII.4.2_Provider Data Exchanges.pdf a. Citation: Entire document 3. XIII.4.3_Provider Data Quality Reports (GBD).docx a. Citation: Page 1 4. XIII.4.4_Ack of Receipt and Received Date for EDI Submissions.docx a. Citation: Pages 1 & 2	
MCO Description of Process: Anthem acquires provider data from a variety of sources – to include the State, vendors, partners and applications. Data is securely transmitted based on pre-determined frequencies. Credentialing, NPI, demographic and location data is obtained, edited and loaded into Anthem's core systems and made available for Managed Care functions.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
5. The MCO must make all collected data *outlined in the Contract, DHCFP's electronic MoveIt reporting repository, or any successor repository, attachments, and guidance* available to the DHCFP and upon request to CMS. 42 CFR § 438.242(b)(4) Contract 7.12.4.1.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements/reports Encounter data acceptance/rejection reports **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 a. Citation: Encounters - Pages 12 & 13 b. Citation: Reporting - Pages 24 & 25 c. Citation: Data Exchanges – Pages 33 & 34 2. XIII.5.2_Encounter-Professional_837P_MCO_Companion_Guide_-_Mod.pdf Institutional_837I_MCO_Companion_Guide_-_Mod.pdf NCPDP_Encounter_companion_Guide.pdf	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Regulatory Compliance Reporting: The department determines which databases and tables are needed for State and CMS reporting requirements. Each day copies of the required data are migrated to the reporting servers and used entirely for reporting and data extracts. In the event new data sources are required, the department meets with the appropriate data managers to determine the best approach to replicate data on the reporting server. Encounters: Anthem follows standard X12 reporting guidelines, per State of Nevada's contractual requirements listed in the Companion Guides for the submission process for all Encounters. A HIPAA validation ensures the 837 transactions are compliant before submission. Anthem's subcontractor policy is to ensure that all vendors – e.g. pharmacy - follow the standard X12 837 and NCPDP formats for submitting encounter transactions in a timely, complete and accurate manner in order to meet Anthem's data quality standards. HIPAA and Encounter data errors are reported to the subcontractors using Anthem's internal 997, 277CA, and 835 response files. Errors are monitored and reviewed regularly with vendors for correction and resubmission.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
Member Eligibility Database		
6. *The MCO's enrollment system is capable of linking records for the same member that are associated with different Medicaid and/or Nevada Check Up identification numbers (e.g., members who are re-enrolled and assigned new identification numbers).* Contract 7.12.3.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 Citation: Enrollment - Pages 8 & 9 2. XIII.1.e_Membership Load - Facets	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Application Programming Interface		
7. The MCO must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCO. Information must be made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the MCO:** 1. XIII.7.1_CMS Interoperability Key Milestones-Timeline.pdf a. Citation: Entire document 2. XIII.7.2_Interoperability Overview and Functionality Walkthrough.pptx	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the MCO; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 Contract 7.12.6; 7.12.6.1.1-7.12.6.1.4	a. Citation: Pages 1 – 7, 9, 12 - 20 3. XIII.7.3_AN.399.InteroperabilityTechnical Guidance_DSE.32.1-DSE.32.3.docx a. Citation: Entire document 4. XIII.7.4_CMS IO Mandate API's_Generic Designs.pdf a. Citation: Pages 1 & 3 5. XIII.7.5_CMS Interoperability Privacy Educational Materials.pdf a. Citation: Entire document 6. XIII.7.6_CMS IO Consent to Send Data to Third-Party App.pdf a. Citation: Entire document 7. XIII.7.7_Member Exp IO Consent Rev Procedure.pdf a. Citation: Entire document	
MCO Description of Process: Anthem/Elevance has implemented the Patient Access API, Provider API and Formulary API – Go Live 7/1/2021 – according to the CMS Interoperability mandate. Payer to Payer API for Medicaid is still In-Progress as of 7/1/2022. Industry standards were used to implement the technical solution.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
8. The MCO must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2).	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Link to web-based provider directory(ies) • HSAG will use the results from the web-based provider directory demonstration	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) Contract 7.8.8.3-7.8.8.4	**Evidence as Submitted by the MCO:** 1. XIII.7.1_CMS Interoperability Key Milestones-Timeline.pdf a. Citation: Entire document 2. XIII.7.2_Interoperability Overview and Functionality Walkthrough.pptx a. Citation: Pages 1 - 5 & 8 3. XIII.7.4_CMS IO Mandate API's_Generic Designs.pdf a. Citation: Page 2 4. XIII.7.3_AN.399.InteroperabilityTechnical Guidance_DSE.32.1-DSE.32.3.docx a. Citation: Entire document 5. Web-based Provider Directory Links: The directories on the API are the same as the site directories. a. Find a Doctor | Anthem Blue Cross Blue Shield Nevada Medicaid	
MCO Description of Process: Anthem has implemented the Patient Access API, Provider API and Formulary API – Go Live 7/1/2021 – according to the CMS Interoperability mandate. Payer to Payer API for Medicaid is still In-Progress as of 4/1/2022. Industry standards were used to implement the technical solution.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Member Encounter Data		
9. The MCO must collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) Contract 7.12.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 a. Citation: Encounters - Pages 12 & 13	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The "Anthem_GBD_MIS" document provides an overview of the data flow and processes that support provider services for members.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. The MCO must submit member encounter data to DHCFP *within ninety (90) calendar days of receipt of the encounter and in the appropriate CMS-1500 and UB-04 format or an alternative format if prior approved by DHCFP,* based on program administration, oversight, and program integrity needs. a. The member encounter data must include all DHCFP-specific requirements for encounter data submissions, including allowed amount and paid amount, that DHCFP is required to report to CMS under 42 CFR §438.818. b. The member encounter data must be submitted to DHCFP in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent encounter submissions compliance reports (acceptance/rejection reports) • Excerpts of encounter data files for professional, institutional, and pharmacy **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 a. Citation: Encounters - Pages 12 & 13 2. XIII.10.1_Electronic Transactions Standard.docx	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.242(c)(2-4) Contract 7.12.4.2-7.12.4.8	a. Citation: Page 1 3. XIII.5.2_Encounter-Professional_837P_MCO_Companion_Guide.pdf Institutional_837I_MCO_Companion_Guide .pdf NCPDP_Encounter_companion_Guide.pdf 4. XIII.10.4_Nevada_Transmission&Submission_Manual.pdf 5. XIII.10.5_Edifecs_end_to_End_Process_flows.pdf 6. XIII.10.6_HL_Encounters_Business_process_2022.pdf 7. XIII.10.7_Encounter Submission – NV_Poloicy_n_Procedure.docx 8. XIII.10.8_NV Submission Summary_202200415.docx XIII.10.8_NV Submission Summary_20220428.docx XIII.10.8_NV Submission Summary_20220512.docx 9. XIII.10.9_InstClaim_Encounter_EP2221276604900ANVMD00.dat 10. XIII.10.10_ProfClaim_Encounter_EP221665329600ANVMD00.dat 11. XIII.10.11_Q1_PaidDate_Internal_Exception.docx 12. XIII.10.12_Q1_PaidDate_External_Exception.docx 13. XIII.10.13_Q1_PaidDate_Checkbook.docx 14. XIII.10.14_NV_Pharmacy_NCPDP_Encounter_4030927239.dat	
MCO Description of Process: Member encounter data is submitted bi-weekly in accordance with the contract that Encounter data shall be submitted by the 20th of the month subsequent to the month for which data are reflected. The Encounter Management team closely tracks the compliance requirements for submission SLAs, completeness, accuracy and timeliness. Anthem complies with the expectation to submit all member encounter data adjudicated for paid and denied claims required by the State per the State's Companion Guides. Claim data – e.g. Allowed Amount and Paid Amount – is reflected on the encounter submitted to the State.		

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Requirement	**Supporting Documentation**	**Score**
Anthem follows ASC X12 TR3 and NCPDP formats for submitting encounter transactions when submitting to the State. Amerigroup adheres to State contractual requirements, listed in the State's Medicaid Companion Guides and MCO Interface Guides for submission of Member and Provider encounter data.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The MCO is required by its contract with DHCFP to pay 99 percent of all clean claims within 90 calendar days of the date of receipt and also submit encounter data to DHCFP within 90 calendar days of receipt of the claim. Therefore, if the MCO paid/denied a clean claim on day 90, the encounter data would need to be submitted to DHCFP that same day to be compliant with the 90-calendar-day time frame for encounter data submissions. Depending on when the encounter data are submitted to DHCFP, the MCO theoretically could be out of compliance with the 90-calendar-day time frame for encounter data submission but still be compliant with the 90-calendar-day time frame for paying/denying clean claims. As such, HSAG recommends that the MCO consult with DHCFP to obtain clarification on the expectations for submitting encounter data to DHCFP within 90 calendar days of receipt of the claim when the contract also allows the MCO 90 calendar days to pay/deny a clean claim within 90 calendar days of receipt of the claim. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Claims Payment		
11. *The MCO has written policies and procedures for processing claims submitted for payment from any source and shall monitor its compliance with these procedures.* Contract 7.7.1.5-7.7.1.7	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims processing guidelines • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 c. Citation: Claims - Pages 10 & 11 d. Citation: Encounters - Pages 12 & 13 2. XIII.2_Alterations to Claims and Encounters 3. XIII.1.b_Claims Process.pdf 4. XIII.11.4.Prompt Pay Requirements-NV.docx	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	5. XIII.11.5_NV Claims Activity and Inventory Report.xlsx 6. XIII.11.6_Acceptance of Altered Claims.doc 7. XIII.11.7_Claims Interest Payments – NV.doc 8. XIII.11.8_Administrative Exceptions.doc 9. XIII.11.9_Claim Timely Filing Standard.docx	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Information Technology System for Care Management Programs		
12. *The MCO's information technology system for its Care Management program maximizes the opportunity for communication between the MCO, PCP, the member, other service providers, and case managers.* Contract 7.5.6.8.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 2. XIII.12.2_Care_Management Rev.docx	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. *The MCO has an integrated database that allows MCO staff that may be contacted by a member in Case Management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case,*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
including the MCO's 24-hour Nurse Line. The integrated database must include all of the following: a. *Administrative data* b. *Call center communications (contact tracking)* c. *Service authorizations* d. *HL7 inpatient and ER notifications* e. *Person centered care treatment plans* f. *Patient assessments* g. *Case management notes* Contract 7.5.6.8.2; 7.5.6.8.4	**Evidence as Submitted by the MCO:** 1. XIII.1_Anthem_GBD_MIS_v2.1 2. XIII.13.1_Care Coordination – NV.docx 3. XIII.12.2_Care_Management Rev.docx	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Electronic Visit Verification		
14. *The MCO implements the State's contracted Electronic Visit Verification (EVV) system for the following services:* a. *Personal Care Services, upon the Contract go-live date.* b. *Home Health Services, no later than January 1, 2023.* c. *Any additional services identified by DHCFP.* Contract 7.12.7	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** 1. XIII.14_EVV Workflow.pdf 2. XIII.14.A_ACR_NEVADA_ANTH_CLIENT_20220531.xml 3. XIII.14.A_ACR_NEVADA_ANTH_CLIENT_20220531.xml	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, sub-element (c) was not applicable to the time period of review.		
Required Actions: None.		

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Met	=	14	X	1	=	14
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	14	Total Score		=	14
Total Score ÷ Total Applicable					=	100%

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program (*referred to as the Internal Quality Assurance Program [IQAP] in Nevada*) for the services it furnishes to its members. a. *The QAPI program consists of systematic activities, undertaken by the MCO, to monitor and evaluate the care delivered to members according to predetermined, objective standards, and effect improvements as needed.* 42 CFR §438.330(a)(1) Contract 7.9.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** 2021 QM PE 2022 Q1 QMC Work Plan Quality Management Program Oversight	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Key Performance indicators are trended over time with a barrier analysis and interventions implemented where appropriate. Each area described below is captured from separate reporting obtained over the course of 2021. Each year, a new Quality Evaluation document is created with trends and updated interventions. Areas Include: 1. Pg. 4: Quality of Clinical Care and Safety 2. Pg. 5: Continuity and Coordination of Care between PH and BH 3. Pg. 11: Population Health Program Impact 4. Pg. 12: Pharmacy DUR and Drug Recall 5. Pg. 14: Population Health Case and Disease Management 6. Pg. 15: Performance Improvement Projects (PIPs) 7. Pg. 18: Healthcare Effectiveness Data and Information Set (HEDIS®)[A-1] centered Interventions 8. Pg. 21: Quality of Service (member perspective)		

[A-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
9. Pg. 23: Cultural Needs and Preferences-members, providers and associates 10. Pg. 31: Network Access-for members 11. Pg. 34: Network Availability-member appointments 12. Pg. 35: Network Adequacy-GeoAccess 13. Pg. 37: Physician Directory-Accuracy 14. Pg. 38: Credentialing and Re-Credentialing 15. Pg. 38: Delegation Oversight 16. Pg. 39: A summary of the effectiveness of the 15 areas outlines above		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. *The MCO must submit a QAPI program description and progress report using the template required by DHCFP by March 30 annually. The program description must:* a. *Encompass all levels of the MCO's organization.* b. *Have a clear linkage to DHCFP's Quality Strategy.* Contract 7.9.2.5	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Evidence of QAPI program submission to DHCFP **Evidence as Submitted by the MCO:** 2022 QI PD Anthem Nevada Trilogy Submission	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Health Care Solutions includes how the QAPI encompasses all levels of the organization and has a clear linkage to DHCFP's Quality Strategy. Please see the Program Description and Work Plan submitted as evidence. Also, Anthem would like to advise that we have not received a QAPI template for 2022, however you will see the email attached "Anthem Nevada Trilogy Submission" includes the October 2021 submission for the 2022 contract along with an updated email submission in June 2022 advising we are aware and awaiting the new template for the 2023 March submission.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of QAPI Programs		
3. *The written QAPI program description must contain a detailed set of quality assurance objectives that are developed annually and include a timetable for implementation and accomplishment.* Contract 7.9.3.1.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** Item 3 2022 QI PD and Workplan	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Health Care Solutions has provided the 2022 QI Program Description and 2022 QI Workplan as evidence of this item. Please see the bookmarked file for the following information: Quality Assurance Objectives listed on pg. 8&9. Pg. 11: Key Program Initiatives The Program Description is a high level overview of the programs to be executed in 2022. The Work Plan is sent as an addendum to the Program Description and reviewed quarterly through the Quality Management Committee where the plan President is chairperson		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While the 2022 QI Program Description and Work Plan identified program objectives, HSAG strongly recommends that the MCO enhance its QAPI program documents to provide additional detail of the QAPI program objectives in the QAPI workplan, including specific data-driven and measurable goals. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
4. *The scope of the QAPI program is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service.* a. *The scope includes availability, accessibility, coordination, and continuity of care.* Contract 7.9.3.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** Item 4 2022 QI PD	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The scope as described on pages 6 includes availability, accessibility, coordination and continuity of care with a more detailed explanation for access and availability (page 11), and continuity and coordination of care (page 13)		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
5. *The written QAPI program description provides for continuous performance of the activities, including tracking of issues over time.* Contract 7.9.3.4	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** Item 5 2022 QI PD	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Anthem Blue Cross and Blue Shield Healthcare Solutions utilizes a Continuous Quality Improvement philosophy and incorporates this into our work. We track and trend data over multiple measurement periods (typically 12 months) to use in comparative analysis and gauge how the plan is operating in a quality sense. This is evident in our annual QI Program Evaluation, and in our Work Plan, where goals are documented along with performance results. These goals are carried over to the following year if the goal is not met. Goals may be modified year to year based on comparative analysis conducted year to year after completion of annual benchmarking.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. The QAPI program must include mechanisms to assess both underutilization and overutilization of services *and appropriate follow up.* a. *If fraud and abuse is suspected, a referral was made to the MCO's program integrity unit and DHCFP Surveillance and Utilization Review (SUR) Unit for appropriate action.* 42 CFR §438.330(b)(3) Contract 7.9.4.5.4	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • Evidence demonstrating assessment of underutilization and overutilization of services (e.g., committee meeting minutes, reports) • Evidence of underutilization and overutilization of services follow-up actions **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	2022 UM Program Evaluation April 2022 Monthly Metric Review February 2022 Monthly Metric Review Final 3.29.2022 CSC Agenda and Meeting Minutes GBD-UM-015 Over Under-Utilization of Services, Whole policy and Nevada Specific on Pg. 6 Item 6 FWA March 2022 Monthly Metric Review NV Care Management Program Description 2022, Pge 71-73 NV Utilization Management Program Description 2022, Pgs 4-6, 8, 36-37	

MCO Description of Process: QM PD pg. 8: 5th bullet: Standard used to determine over and under utilization
Attachment A UM Program Evaluation pg. 12. Over and Under-Utilization monitoring
P&P Investigations of Suspected Fraud and Abuse: Waste and abuse investigations
P&P Medicaid Compliance Investigations: feeds lead into investigations when appropriate
P&P Fraud, Waste, and Abuse Detection and Prevention in Health Plan Operations: Detection during the normal course of business
P&P Reporting of Fraud and Abuse Investigations: How the investigation is reported
P&P Medicaid Internal Corrective Action Plan (iCAP): Corrective Action plan execution

Utilization trends are continuously monitored by the Health Plan, with daily review of the Member census, clinical case volumes, and Turnaround Time oversight. Historically, clinical teams, including Utilization Management and Care Management, formally monitor utilization and audit trends monthly with a minimum of quarterly reporting to clinical leadership; however, results were not always shared with other functional teams. Similarly, other functional areas including Quality Management, reviewed utilization trends, including HEDIS, without frequent collaboration with other Health Plan departments. Starting in June 2022, a proposed multi-disciplinary Over and Under Utilization Workgroup was approved in the Clinical Services Committee forum for all Health Plan functional areas to review and participate in all Health Plan Over and Under Utilization monitoring. The purpose of this workgroup is to help breakdown siloes between functional areas and promote holistic oversight of Member utilization, with promotion of innovative actionable interventions. The workgroup started meeting monthly in June 2022 with reporting to Clinical Services Committee quarterly. Clinical Services Committee meeting minutes are reported and approved in Quality Management Committee (QMC) and Medical Advisory Committee (MAC).

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. The QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by DHCFP in the Quality Strategy. a. *The QAPI program methodology must provide for review of the entire range of care provided by the MCO, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.* b. *The review of the entire range of care must be carried out over multiple review periods and not on a concurrent basis.* c. *This review occurs no less than annually.* 42 CFR §438.330(b)(4) Contract 7.9.3.2.2	**HSAG Recommended Evidence:** • QAPI program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the MCO:** Item 7 2022 QI PD BH General Adult Assessment BH General Pediatric Assessment SHCN Audit Tool Final GBD Adult CM Initial Assessment GBD CM OB Assessment GBD Pediatric CM Initial Assessment Health Needs Assessment Screener NICU Post Discharge Management Screening Assessment NICU PTSD Initial Screening HRA NV Care Management Program Description 2022, Pgs 28-32, 53-55 NV Case Management Screener NV NEIS Screener OB High Risk Screener Behavioral Health Continued Access to Care, Pgs 2-4, 18 Children with Special Health Care Needs x1v 6 - NV, All Coordination of Care – NV, Pgs 2-4	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	GBD-UM-127 Continuity of Care - Core Process, All, Pgs, 29-30 GBD-CM-109 Case Management Perpetually Open Cases Due to Contractual Req, Pgs 1-5 GBD-CM-102 Complex Case Management (Care Compass), Pgs 1-14, 17 Identification and Monitoring for Special Health Care Needs – NV, All Transition of Members care to the Health Plan – NV, Pgs 1-4	
MCO Description of Process: Please see the evidence provided for this required action in the provided file. The items can be found: a: QM PD pg. 10. Methodology shows the entire range of the population covered by Anthem b&c: QM PD pg. 11. Frequency of data collection and are highlighted and bookmarked within the document. Clinical teams, including Utilization Management and Care Management, continually assess members for comprehensive health needs, including highest tier Case Management: Special Health Care Needs. Members are identified as having physical health, behavioral health, social determinants of health, and/or co-morbid conditions through a variety of sources including, but not limited to, our new enrollee Health Needs Assessment Screener, Utilization Management review, Care Management Comprehensive Health Risk Assessments, and/or member or provider referral. Once identified as needing assistance from our clinical teams, Care Management will continuously monitor Member needs, completing annual health assessments and updating the Person Centered Care Treatment Plan at least monthly while the case is active in Care Management, or at least every 90 days for cases in Special Health Care Needs that are perpetually monitored and not in active status. Care Management reviews Special Health Care Needs cases monthly for any newly identified needs or trends, such as Emergency Room or hospital visits, that may warrant an urgent follow up call, or will contact the Member at least every 90 days for a check-in on health status. Furthermore, Care Management will work with Utilization Management to ensure appropriate services are in place, or Concierge Services to help the Member find appropriate providers and/or schedule appointments. Cases in Care Management Special Health Care Needs are monitored internally with a SHCN Audit Template to verify Care Managers are following not only the Anthem and NCQA approved charting mandates, but also to ensure HSAG and State charting requirements are met as well. A copy of the SHCN Audit Template has been provided.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
8. The QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i) Contract 7.9.3.2.3	**HSAG Recommended Evidence:** • QAPI program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS Audit tools and results **Evidence as Submitted by the MCO:** Item 7 2022 QI PD Transition of Members care to the Health Plan – NV, Pgs 1-4 NV Care Management Program Description 2022, Pgs 28-32, 53-55, 66, 67 NV Utilization Management Program Description 2022, Pgs3, 12-16, 36-37 NV Functional Assessment Service Plan_Instructions NV Case Management Screener BH General Adult Assessment BH General Pediatric Assessment NMO-7073_(7-14)_Functional_Assessment_Form Identification and Monitoring for Special Health Care Needs – NV, All Health Needs Assessment Screener GBD-UM-127 Continuity of Care - Core Process, All, Pgs 29-30 GBD-CM-109 Case Management Perpetually Open Cases Due to Contractual Req, Pgs 1-5 GBD-CM-102 Complex Case Management (Care Compass), Pgs 1-14, 17 GBD Adult CM Initial Assessment GBD CM OB Assessment	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	OB High Risk Screener GBD Pediatric CM Initial Assessment Coordination of Care – NV, Pgs 2-4 Children with Special Health Care Needs x1v 6 - NV, All Behavioral Health Continued Access to Care, Pgs 2-4, 18 NICU Post Discharge Management Screening Assessment NICU PTSDD Initial Screening HRA	
MCO Description of Process: Utilization Management follows the MSM guidelines medical necessity review for Personal Care Services and Home Health Agencies. A sample Functional Assessment form completed as outlined by the MSM is conducted and sent to the Utilization Management team for review. If a Member is identified as needing LTSS services or otherwise identified as having Special Health Care Needs, the Utilization Management team will send the case for referral to Care Management for outreach. Care Management will treat Members receiving LTSS services as Special Health Care Needs, performing all assessments and outreach attempts per Case Management and Special Health Care Needs guidelines.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. While the MCO did not manage the benefits for waiver members, HSAG has determined that this element is applicable as the MCO is responsible for providing LTSS (e.g., personal care services) to its members as medically necessary.		
Required Actions: None.		
Adequate Resources		
9. *The QAPI program must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.* a. *The MCO dedicates sufficient staff to fulfill the MCO's set of clearly defined functions and responsibilities, so that staffing is proportionate to and adequate for the planned number of and types of quality improvement (QI) initiatives within the managed care program.* b. *A QI Manager is dedicated to the managed care program with reporting authority to the MCO's medical director.*	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job descriptions • Training materials **Evidence as Submitted by the MCO:** Item 9 - 2022 QI PD QM Lead Job Description Do the Right Thing Training	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.4.13; 7.9.4.13.1	Medicaid Cultural Competency Refresher Training	
MCO Description of Process: The provided evidence shows the resources dedicated to the Plan's QM Program and is explained within the documents. Please see the bookmarked evidence within the document. **Note:** As of July 8, 2022, the Quality Management Director position is vacant. Her position has been posted and an interim director is in place. The interim director reports to the plan president. As of August of 2022, the Quality Management department is fully staffed in anticipation of the new director.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. *The MCO must have QI teams composed of MCO staff fully dedicated to the managed care program that represent the following areas of expertise:* a. *Continuous quality improvement.* b. *Analytics.* c. *Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts.* d. *Health equity.* e. *The MCO's policies and processes related to the improvement topic.* f. *Member and provider perspectives (may be staff or liaisons with the MCO's member and provider services departments).* Contract 7.9.4.13.2; 7.9.4.13.2.1-7.9.4.13.2.6	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart **Evidence as Submitted by the MCO:** Item 9 - 2022 QI PD	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Quality Assurance Committee		
11. *At a minimum, the MCO's quality committee structure must include the following committees:* a. *Executive Committee* b. *Quality Management Committee that reports to the Executive Committee* c. *Utilization Management (UM) Subcommittee that reports to the Quality Management Committee* d. *Care Management Subcommittee that reports to the Quality Management Committee* e. *Member Services Subcommittee that reports to the Quality Management Committee* f. *Member Advisory Board that reports to the Quality Management Committee* g. *Provider Services Subcommittee that reports to the Quality Management Committee* h. *Provider Advisory Board that reports to the Quality Management Committee* Contract 7.9.4.11.1; 7.9.4.11.1.1-7.9.4.11.1.8	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure **Evidence as Submitted by the MCO:** Item 11 - 2022 QI PD	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
12. *The structure/committee meets on a regular basis with a specified frequency, no less than quarterly to oversee QAPI program activities.* a. *This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* Contract 7.9.4.11.2	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • All committee charters under the structure • Three consecutive committee meeting minutes for each committee under the structure **Evidence as Submitted by the MCO:** Item 13 2022 QI PD Charter Minutes Item 11 - 2022 QI PD	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Please note, committee meeting occur quarterly. There is only 1 meeting with minutes that is applicable to the allowable lookback period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. *There is active participation in the QAPI committee from network providers, who are representative of the composition of the MCO's network.* a. *The MCO includes providers on, at a minimum, the UM and Provider Services Subcommittees.* Contract 7.9.4.11.6; 7.9.4.14.4	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • All committee charters under the structure, with a list of providers who serve on the QAPI committee(s) • Three consecutive committee meeting minutes for each committee under the structure **Evidence as Submitted by the MCO:** Item 13 2022 QI PD Charter Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Please note, committee meeting occur quarterly. There is only 1 meeting with minutes that is applicable to the allowable lookback period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Required Actions: None.		
14. *The Provider Advisory Board has broad representation of Provider types in the Network, including at least:* a. *One (1) PCP serving children and adolescents;* b. *One (1) PCP serving adults;* c. *One (1) OB/GYN;* d. *One (1) psychiatrist;* e. *One (1) licensed Behavioral Health clinical professional;* f. *One (1) substance abuse professional;* g. *One (1) community-based Care Coordinator or community Case Manager serving a Network Provider;* h. *One (1) peer support specialist or a Behavioral Health Case Manager; and* i. *Other practitioners, such that there is broad representation from across the geographic service area under the Contract.* Contract 7.9.4.14.6	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Provider Advisory Board charter, including a listing of provider names and specialties who serve on the Provider Advisory Board • Three consecutive committee meeting minutes for the Provider Advisory Board **Evidence as Submitted by the MCO:** Item 14 2022 QI PD Charter Minutes 2022 1st qtr CAC meeting minutes 2022 QI PD, Pg 23, Pg 27, Pg 37 Appendix D Member_Provider Advisory Board Minutes Submission Item 17	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The plan is actively attempting to recruit providers to sit on the Medical Advisory Committee. We will be outreaching our established committee members and putting an article in our next provider newsletter to announce we are looking for members. We anticipate that we will be able to recruit practitioners to come into compliance and have broad representation from across our service area. There is only 1 committee meeting that has occurred within the applicable lookback period. Per contract section 7.9.4.14.7. The Provider Advisory Board is required to meet quarterly with minutes submitted to the State within thirty (30) Calendar Days of the Meeting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO received a *Met* score for this element as the MCO has been actively recruiting network providers to serve on its Medical [Provider] Advisory Board. Additionally, due to the shortened review period, only one quarterly meeting occurred during the time period under review.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG strongly recommends that the MCO have strategies in place to ensure the MCO has and continues to have broad representation of network providers who actively participate in the Medical [Provider] Advisory Board to maintain compliance with the requirements for this element. The MCO's implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
15. *The Provider Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.* Contract 7.9.4.14.7	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Provider Advisory Board charter • Three consecutive committee meeting minutes for the Provider Advisory Board Evidence of submission of each set of minutes to DHCFP **Evidence as Submitted by the MCO:** 2022 1st qtr CAC meeting minutes 2022 QI PD, Pg 23, Pg 27, Pg 37 Appendix D Member_Provider Advisory Board Minutes Submission Item 17 Item 15 2022 QI PD Charter Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There is only 1 committee meeting that has occurred within the applicable lookback period. Per contract section 7.9.4.14.7. The Provider Advisory Board is required to meet quarterly with minutes submitted to the State within thirty (30) Calendar Days of the Meeting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
16. *The MCO develops a Member Advisory Board comprised of a minimum of twelve (12) members or members' designated legal representatives from across the geographic service area under the Contract.* Contract 7.9.4.15.4	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Member Advisory Board charter, including a listing of all members who serve on the Member Advisory Board • Three consecutive committee meeting minutes for the Member Advisory Board **Evidence as Submitted by the MCO:** Item 16 2022 QI PD, Pg 23, Pg 27, Pg 37 Appendix D 2022 1st qtr CAC meeting minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There is only 1 committee meeting that has occurred within the applicable lookback period. Per contract section 7.9.4.15.5. The Member Advisory Board is required to meet quarterly.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
17. *The Member Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.* Contract 7.9.4.15.5	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Member Advisory Board charter • Three consecutive committee meeting minutes for the Member Advisory Board • Evidence of submission of each set of minutes to DHCFP **Evidence as Submitted by the MCO:** 2022 1st qtr CAC meeting minutes 2022 QI PD, Pg 23, Pg 27, Pg 37 Appendix D	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	Member_Provider Advisory Board Minutes Submission Item 17	
MCO Description of Process: The Anthem Blue Cross Blue Shield Healthcare Solutions plan has had a Member Advisory Board in place since 09/2021. Our Board is set to meet at least quarterly with the following dates already scheduled for 2022: 03/24/2022, 06/30/2022, 09/13/0222, and a date to be determined in December. Minutes are completed by the Member Advisory Board Facilitator, which are in turn provided to our Compliance team, and forwarded on to DHCFP within 30 days of the meeting. There is only 1 committee meeting that has occurred within the applicable lookback period. Per contract section 7.9.4.15.5. The Member Advisory Board is required to meet quarterly.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
18. *The MCO develops methods to encourage and ensure adequate member participation in the quarterly Member Advisory Board meetings, including but not limited to:* a. *Accommodating virtual participation* b. *Providing meeting materials ahead of time* c. *Providing meeting materials in literacy level appropriate for participants* d. *Arranging transportation when appropriate* e. *Providing childcare when appropriate.* Contract 7.9.4.15.6	**HSAG Recommended Evidence:** • QAPI program description • Three consecutive committee meeting minutes for the Member Advisory Board • Processes to encourage and ensure member participation **Evidence as Submitted by the MCO:** 2022 1st qtr CAC meeting minutes 2022 QI PD, Pg 23, Pg 27	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There is only 1 committee meeting that has occurred within the applicable lookback period. Per contract section 7.9.4.15.5. The Member Advisory Board is required to meet quarterly.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Performance Measurement		
19. The QAPI program must include the collection and submission of performance measurement data. The MCO must annually: a. Measure and report to DHCFP on its performance, using the standard measures required by DHCFP; b. Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP; or c. Perform a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) Contract 7.9.2.9-7.9.2.9.10	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Performance measures reports • Evidence of submission of performance measurement reports to DHCFP (e.g., HEDIS Final Audit Report) **Evidence as Submitted by the MCO:** Item 22 – 2022 QI PD, Pg 8, Quality Management Program Objectives DATAWORKBOOK11072 DATAWORKBOOK11073 FAR_14509_1_v2 RE_2022 HEDIS Reports	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Performance Improvement Projects		
20. The QAPI program must include performance improvement projects (PIPs). a. *The MCO annually conducts and reports on a minimum of three (3) clinical PIPs and three (3) non-clinical PIPs.* i. *The MCO participates in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by DHCFP.*	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** Item 22 – 2022 QI PD	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
ii. *The MCO selects an additional two (2) projects from the list below, to serve as the MCO's required PIPs in accordance with 42 CFR §438.330(a)(2) and 42 CFR §438.358:* 1. *Increasing access to and use of primary care and preventive services across the covered population.* 2. *Improving quality of and access to Behavioral Health Services.* 3. *Reducing preventable thirty (30) day hospital readmissions.* 4. *Social determinants of health and health equity.* Note: Refer to Plan Year 2022 PIP Memorandum for MCOs from DHCFP 5-19-2022. 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) Contract 7.9.5.4-7.9.5.6	2022 QM PE, PIP Topics Plan Year 2022 PIP Memo (for upcoming PIPs) Anthem_NV2019-20_PDSA_CDC_PIP_Worksheet_Intervention1_Final Anthem_NV2019-20_PIP-Cycle1_PPC_PDSA Worksheet_Final_10.14.21 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21	
MCO Description of Process: PIP information included from 2021 as 2022 PIP information was just shared recently and would be available during the applicable lookback period. This information can be verified based on the PIP Memo included for your review.		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
21. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements: a. Measurement of performance using objective quality indicators.	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by DHCFP. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) Contract 7.9.5.2; 7.9.5.2.1-7.9.5.2.4	**Evidence as Submitted by the MCO:** Item 22 – 2022 QI PD 2022 QM PE, PIP Topics Plan Year 2022 PIP Memo (for upcoming PIPs) Anthem_NV2019-20_PDSA_CDC_PIP_Worksheet_Intervention1_Final Anthem_NV2019-20_PIP-Cycle1_PPC_PDSA Worksheet_Final_10.14.21 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the QI Program Description and prior PIP cycle submission documentation included the requirements for this element, DHCFP did not announce the required PIP topics to the MCOs until May 2022. Therefore, HSAG did not evaluate implementation of the requirements under this element. The MCO's compliance with all PIP-related requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
22. *The MCO's PIPs are described in the annual written QAPI program description and include:* a. *How the PIP relates to the MCO's other Population Health initiatives and DHCFP's Quality Strategy.*	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:**	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. *The theory of change for each PIP (e.g., cause and effect diagrams, key driver diagrams).* c. *Criteria considered when choosing and prioritizing the MCO's PIPs by population stream.* d. *The MCO's evaluation strategy addressing the process, outcome, and balancing measures for each initiative, including:* i. *Baseline, milestones, and target goals.* ii. *Timeframes for baseline, milestones, and target goals.* iii. *Data sources.* iv. *Numerator and denominators for each measure.* v. *Frequency of measurement (e.g., daily, weekly, monthly)* Contract 7.9.5.8;7.9.5.8.1-7.9.5.8.4; 7.9.5.8.4.1-7.9.5.8.4.4	Item 22 – 2022 QI PD 2022 QM PE, PIP Topics Plan Year 2022 PIP Memo (for upcoming PIPs) Anthem_NV2019-20_PDSA_CDC_PIP_Worksheet_Intervention1_Final Anthem_NV2019-20_PIP-Cycle1_PPC_PDSA Worksheet_Final_10.14.21 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21	
MCO Description of Process:		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
23. The MCO must report the status and results of each PIP to DHCFP as requested, but not less than once per year. a. *Each PIP is completed in a reasonable time period so as to generally allow information on the success of PIPs to be available to DHCFP for its annual review of the MCO's QAPI program.* 42 CFR §438.330(d)(3)	**HSAG Recommended Evidence:** • Evidence of annual submission, including the documentation that was submitted, of all PIPs to DHCFP **Evidence as Submitted by the MCO:** PIP Anthem_NV2019-20_PDSA_CDC_PIP_Worksheet_Intervention1_Final	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.2.8; 7.9.5.3	Anthem_NV2019-20_PIP-Cycle1_PPC_PDSA Worksheet_Final_10.14.21 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 Anthem_NV2020-21_PIP-Cycle2_PPC_PDSA Worksheet_Final_10.14.2021 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21 NV20109-20_Anthem_PIP-Val_Module 4_Submission Form_V5_CDC HbA1c Poor Control_Final V1_10.14.21	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Critical Incident Management System		
24. The QAPI program must include participation in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). 42 CFR §438.330(b)(5)(ii) Contract 7.9.14	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident reports • Committee meeting minutes Provider remediation plan template(s) **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCO include detailed information within its QAPI-related documents (e.g., program description, workplan, annual evaluation) about the MCO's participation in DHCFP's efforts to prevent, detect, and remediate critical incidents. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
25. *The MCO must designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of Section 7.9.14 of the Contract.* a. *This position may be assigned as a responsibility to a lead within the quality department and may or may not be a full time equivalent (FTE).* Contract 7.9.14.1	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart Job description **Evidence as Submitted by the MCO:** 2022 QI PD, pg 38 QM Lead Job Description Quality of Care – Core Procedure Item 24 NV Critical Incident Reporting Procedure CIR process_v3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions Plan has designated our Director of Quality Improvement to serve as our Critical Incident Manager. As lead QI Associate, the Director of Quality Improvement administers the incident management system and ensures the plan's compliance with Section 7.9.14 of the Contract. While the job description does not specifically state this responsibility, it is a part of "other assigned responsibilities". Our Director of Quality Job Description that is used, comes from our corporate HR partners, where a large amount of work has occurred to align our job roles and responsibilities across the Enterprise. We are allowed to assign other responsibilities to the Director of Quality Improvement to meet the needs of the individual markets the Enterprise operates in. Please see the Director of Quality Improvement Job Description and the Critical Incident Desktop Process that outlines the work completed surrounding Critical Incidents.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
26. The MCO develops and implements policies and procedures, subject to DHCFP review and approval, to: a. Address and respond to incidents. b. Report incidents to the appropriate entities per required timeframes. c. Track and analyze incidents. 42 CFR §438.330(b)(5)(ii) Contract 7.9.14	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports • Committee meeting minutes with aggregated critical incident analysis • Provider remediation plan template(s) **Evidence as Submitted by the MCO:** 2022 QI PD Quality of Care – Core Procedure CI #1 Redacted CI #2 Redacted Item 24 NV Critical Incident Reporting Procedure CIR process_v3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan has implemented a robust process to address and respond to incidents, report incidents to the appropriate entities per required timeframes, and to track and analyze incidents. We are submitting our desktop process for handling Critical Incidents, as defined by the Nevada Medicaid Contract, and a process flow document showing the pathway of a Critical Incident from initial receipt to disposition and close of the incident. We have also submitted 2 Critical Incident files, that will provide evidence of our plan following the established process and a provider remediation plan template. At the current time, the Plan, has not reported out Critical Incidents to the Quality Management Committee, but has planned to begin this process in Q 3 of 2022.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG strongly recommends that critical incident data, including tracking, trending, and other analyses reported to the Quality Management Committee also be integrated into the MCO's overall QAPI program. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
27. *The MCO submits an individual critical incident report for the following incidents:* a. *Homicide or attempted homicide by a member.* b. *A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility licensed by the State to provide publicly funded behavioral health services.* c. *An unexpected death of a member that occurs in a facility licensed by the State to provided publicly funded behavioral health services.* d. *Abuse, neglect, or exploitation of a member (not to include child abuse).* e. *Violent acts allegedly committed by a member, to include:* i. *Arson.* ii. *Assault resulting in serious bodily harm.* iii. *Homicide or attempted homicide by abuse.* iv. *Drive-by shooting.* v. *Extortion.* vi. *Kidnapping.* vii. *Rape, sexual assault, or indecent liberties.* viii. *Robbery.* ix. *Vehicular homicide.* f. *Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers,*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** Item 27 Nevada Critical Incident Job Aid Item 24 NV Critical Incident Reporting Procedure 2022 QI PD	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions. g. *Any even involving a member that has attracted or is likely to attract media attention.* Contract 7.9.14.2; 7.9.14.2.1-7.9.14.2.5; 7.9.14.2.5.1-7.9.14.2.5.9		
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan, records and submits appropriate critical incident documentation for each individual critical incident to DCHFP as defined in the contract. At this time the plan has not received any instance where multiple critical incidents have occurred through intake of critical incidents or review through case management processes.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
28. *The MCO reports critical incidents within one (1) business day in which the MCO becomes aware of the event. The report must include:* a. *The date the MCO became aware of the incident.* b. *The date of the incident.* c. *A description of the incident.* d. *The name of the facility where the incident occurred, or a description of the incident location.* e. *The name(s) and age(s) of member(s) involved in the incident.* f. *The name(s) and title(s) of facility personnel or other staff involved.* g. *The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident timeliness reports • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** 2022 QI PD Quality of Care – Core Procedure CI #1 Redacted CI #2 Redacted Item 24 NV Critical Incident Reporting Procedure CIR process_v3	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
h. *The member's whereabouts at the time of the report, if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by the MCO to locate the member.* i. *Actions planned or taken by the MCO to minimize harm resulting from the incident.* j. *Any legally required notifications made by the MCO.* Contract 7.9.14.3; 7.9.14.3.1-7.9.14.3.10		
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan abides by the contractual obligation to submit all critical incidents to DHCFP within 1 business day. This process is defined in the Critical Incident Desktop Process that has been provided and is evidenced in the files that have been provided for this requirement.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
29. *The MCO submits follow-up reports using the Incident Reporting System and closes the case within forty-five (45) calendar days after the critical incident was initially reported. A case cannot be closed until the following information is provided:* a. *A summary of any debriefings.* b. *Whether the member is in custody (jail), in the hospital, or in the community.* c. *Whether the member is receiving services and include the types of services provided.* d. *If the member cannot be located, the steps the MCO has taken to locate the member using available, local resources.* e. *In the case of the death of a member, verification from official sources that includes the date, name, and title of the sources.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports with resolutions • Committee meeting minutes • Critical incident timeliness reports **Evidence as Submitted by the MCO:** Item 24 NV Critical Incident Reporting Procedure 202 QI PD CIR process_v3	☐ Met ☒ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
When official verification cannot be made, the MCO must document all attempts to retrieve it. Contract 7.9.14.4; 7.9.14.4.1-7.9.14.4.5		
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan acknowledges that the critical incidents that were identified have not had resolution within 45 days of reporting. This process will need to be refined and instituted with the Interim Director and then reviewed, dissected, and improved upon identification and hiring of our new Director of Quality Improvement. The team acknowledges this gap and will begin refinement immediately. An internal corrective action plan will be created and initiated within 30 days.		
HSAG Findings: The MCO did not submit follow-up reports using the Incident Reporting System and close the case within 45 calendar days after the critical incident was initially reported as required in the contract. During the site review, MCO staff members acknowledged this gap and explained that the MCO is implementing corrective action.		
Required Actions: The MCO must ensure that it submits follow-up reports using the Incident Reporting System, closes the case within 45 calendar days after the critical incident was initially reported, and ensure the follow-up information required by sub-elements (a) through (e) are included, as applicable.		
Member Participation in the QAPI		
30. *Members are kept informed about the quality initiatives and results through member newsletters and website postings and through the Member Advisory Board.* Contract 7.9.4.15.1	**HSAG Recommended Evidence:** • Member newsletters and website screenshots demonstrating members are informed of quality initiatives **Evidence as Submitted by the MCO:** Item 30 - Handbook and Screenshot	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Members are informed about the QAPI program via the member handbook. Annually, a postcard is sent to each beneficiary household notifying members where additional information can be found about the QI Program. This information is available on the public website and can be accessed on the public website via the online Member Handbook. An annual overview of the QAPI program, CLAS and Health Disparities, and a high level review of HEDIS findings were presented at the Member Advisory Board in Q 2 2022. These topics were presented by our Director of Quality Improvement, Clinical Compliance Director, and Accreditation Consultant.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Although the MCO posted information for members regarding quality initiatives through website postings, HSAG recommends that the MCO enhance the information posted to include additional detail about the results of the quality initiatives. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Provider Participation in the QAPI		
31. *Network providers and other providers must be kept informed about the written QAPI program through provider newsletters and updates to the provider manual.* Contract 7.9.4.14.1	**HSAG Recommended Evidence:** • Provider newsletters and website screenshots demonstrating providers are informed of quality initiatives • Provider manual **Evidence as Submitted by the MCO:** NV_CAID_ProviderManual, Sec 10 Quality Management Quality management | Anthem Blue Cross and Blue Shield Healthcare Solutions QM Initiatives Screenprint Provider communications | Anthem Blue Cross and Blue Shield Healthcare Solutions	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Providers are informed annually about the QAPI program annually through the Provider Manual. Additionally, Providers are given the number to customer service for any additional inquiries about our Quality Improvement plan and activities, which is available on the public website. The provider handbook and screenshots have been provided as evidence of this.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Plan of Correction Procedure		
32. *The MCO implements a Plan of Correction (POC) to identify improvements and/or enhancements of existing outreach, education, and case management activities, which will assist the MCO to improve the quality rates/scores. A POC must include, but may not be limited to, the following:* a. *Specific problem(s) which require corrective action;* b. *The type(s) of corrective action to be taken for improvement;* c. *The goals of the corrective action;* d. *The timetable for action;* e. *The identified changes in process, structure, internal/external education;* f. *The MCO's staff person(s) responsible for implementing and monitoring the POC;* g. *The POC should also identify improvements and enhancements of existing outreach and case management activities, if applicable.* Contract 7.9.2.7.1-7.9.2.7.9	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active internal POCs during the time period under review **Evidence as Submitted by the MCO:** NV_CAID_ProviderManual, Sec 10 Quality Management Quality Management Program - NV Quality Management Program Oversight Quality of Care - Core Procedure Policy 10 Termination and Immediate Termination Practitioner Office Stie Quality Tool Appointment and Avail survey – CAP example After Hours Survey – CAP example Enterprise Provider Termination Playbook 2022 MNOPT CSBD Medicaid Overview 2021	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There are no active provider POCs during the applicable lookback period		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's Quality Management Program Description, policies, and procedures included all the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
33. *The QAPI includes written procedures for taking corrective action, also referred to as POC and as described in Section 7.9.2.7 of the Contract, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures includes:* a. *Specification of the types of problems requiring corrective action;* b. *Specification of the person(s) or body responsible for making the final determinations regarding quality problems;* c. *Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff;* d. *The schedule and accountability for implementing corrective actions;* e. *The approach to modifying the corrective action if improvements do not occur; and* f. *Procedures for terminating the affiliation with the physician, or other health professional or provider.* Contract 7.9.4.8.1; 7.9.4.8.1.1-7.9.4.8.1.6	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active provider POCs during the time period under review **Evidence as Submitted by the MCO:** NV_CAID_ProviderManual, Sec 10 Quality Management Quality Management Program - NV Quality Management Program Oversight Quality of Care - Core Procedure Policy 10 Termination and Immediate Termination Practitioner Office Stie Quality Tool Appointment and Avail survey – CAP example After Hours Survey – CAP example Enterprise Provider Termination Playbook 2022 MNOPT CSBD Medicaid Overview 2021	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There are no active provider POCs during the applicable lookback period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's Quality of Care – Core Procedure and Termination and Immediate Termination policy and procedure, and CAP template included the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
34. *As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made.* a. *In addition, changes in practice patterns must be monitored.* b. *The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.* Contract 7.9.4.8.2	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • Evidence of monitoring of all active provider POCs during the time period under review **Evidence as Submitted by the MCO:** 2022 QI PD Quality Management Program - NV Quality Management Program Oversight Quality of Care - Core Procedure NV_CAID_ProviderManual, Pg 84 – 93, Sec Quality Management	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There are no active provider POCs during the applicable lookback period available for monitoring.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's Quality of Care–Core Procedure and Termination and Immediate Termination policy and procedure included the requirements for this element.		
Required Actions: None.		
Accountability to the Governing Body		
35. *The governing body has approved the overall QAPI and the annual QAPI.* Contract 7.9.4.10.1	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval **Evidence as Submitted by the MCO:** Item 35 - QIPD, Approvals and Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan brings the annual QAPI through our Quality Committee Structure for review and approval at the plan level. Upon approval, annually, the Plan Director of Quality presents the QAPI to the Medicaid Quality		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Improvement Committee, which has been delegated to be the Medicaid Governing Body by the Board of Directors. On May 12th, 2022, our Director of Quality presented the QI Program Description, 2021 QI Program Evaluation, and 2022 QI Work Plan to the Quality Improvement Committee for review and approval. The final approved minutes for this meeting are provided as evidence.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
36. *The governing body has formally designated an entity or entities within the MCO to provide oversight of the QAPI program and is accountable to the governing body, or has formally decided to provide such oversight as a committee of the whole.* Contract 7.9.4.10.2	**HSAG Recommended Evidence:** • QAPI program description **Evidence as Submitted by the MCO:** Item 36 - QIPD, Approvals and Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Board of Directors has delegated oversight of the QAPI program to the Medicaid Quality Improvement Committee. The plan has submitted documentation of this found in the QI Program Description for 2022. This was presented to the Medicaid Quality Improvement Committee on May 12th, 2022 by the Director of Quality Improvement.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
37. *The governing body routinely receives written reports from the QAPI program describing actions taken, progress in meeting quality assurance objectives, and improvements made.* Contract 7.9.4.10.3	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body Three consecutive governing body meeting minutes **Evidence as Submitted by the MCO:** Item 37 - QIPD, Approvals and Minutes, Bookmarked	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan presents bi-annually to the Medicaid Quality Improvement Committee. On May 12th, 2022, the plan Director of Quality Improvement presented the 2021 QI Program Evaluation, which described the actions taken, progress in meeting quality assurance objectives, and improvements made. We are submitting the 2021 QI Program Evaluation and Medicaid Quality Improvement Committee Minutes from May 12th, 2022 as supportive evidence.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
38. *The governing body formally reviews on a periodic basis, but no less frequently than annually, a written report on the QAPI program.* a. *This annual quality program evaluation report is submitted to DHCFP in the second calendar quarter and at minimum must include studies undertaken; results; subsequent actions and aggregate data on utilization and quality of services rendered; and an assessment of the QAPI's continuity, effectiveness, and current acceptability.* Contract 7.9.4.10.4	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval • Annual written report reviewed by the governing body • Evidence the annual QAPI program evaluation was submitted to DHCFP **Evidence as Submitted by the MCO:** Anthem Nevada Trilogy Submission Item 38 QIPD EVAL MINUTES APPROVALS, (Bookmarked)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan presents bi-annually to the Medicaid Quality Improvement Committee. On May 12th, 2022, the plan Director of Quality Improvement presented the 2021 QI Program Evaluation, which described the actions taken, progress in meeting quality assurance objectives, and improvements made. We are submitting the 2021 QI Program Evaluation and Medicaid Quality Improvement Committee Minutes from May 12th, 2022 as supportive evidence.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
39. *Upon receipt of regular written reports delineating actions taken and improvements made, the governing body takes action when appropriate, and directs that the operational QAPI program be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO.* a. *This activity is documented in the minutes of the meetings of the governing board in sufficient detail to demonstrate that it*	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the MCO:** Item 39 QIPD Eval Minutes Approvals, (See Bookmarks)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
has directed and followed up on necessary actions pertaining to quality assurance. Contract 7.9.4.10.5		
MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions Plan seeks approval from the Local Plan level and the Enterprise Level. The QAPI first is reviewed by the Quality Management Committee where the QAPI is dissected, reviewed, and follow up actions are discussed and approved pertaining to Quality Assurance. The documents are then presented to the Medicaid Quality Improvement Committee for review and approval. The plan has provided final minutes from the QAPI presentation to both the plan's Quality Management Committee and the overarching Medicaid Quality Improvement Committee demonstrating approval of the 2021 QI Evaluation.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
QAPI Program Reviews, Analysis, and Evaluation		
40. The MCO must develop a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation must include: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. d. *Quality assurance studies and other activities completed.* e. *Trending of clinical and service indicators and other performance data.* f. *Demonstrated improvements in quality.* g. *Areas of deficiency and recommendations for corrective action.*	**HSAG Recommended Evidence:** • QAPI program evaluation • Evidence of QAPI program evaluation annual submission to DHCFP **Evidence as Submitted by the MCO:** Anthem Nevada Trilogy Submission Item 40 QIPD Eval Minutes Approvals, (See Bookmarks)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
h. *An evaluation of the overall effectiveness of the QAPI program.* 42 CFR §438.330(e) Contract 7.9.2.4; 7.9.4.9.2		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While the 2021 QAPI evaluation included an evaluation of the state-required PIPs, HSAG recommends that the MCO also include in the annual evaluation the results and outcomes of all internal PIPs conducted during the year. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
41. *The QAPI program evaluation provides evidence that quality assurance activities have contributed to significant improvements in the care delivered to members and include:* a. *A description of DHCFP and MCO-initiated improvement projects, including the annual PIPs; and the outcomes and trended results for each improvement project, including documentation of successful and unsuccessful interventions.* b. *A summary of the MCO's assessment of the effectiveness of improvement projects based on performance measurement data.* c. *A description of how the MCO meets the requirements for the development and dissemination of clinical practice guidelines.* d. *A description of mechanisms the MCO uses to detect both underutilization and overutilization.* e. *A description of mechanisms the MCO uses to assess the quality and appropriateness of care furnished to members with special health care needs and members receiving long-term services and supports.*	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** 2021 QM PE	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
f. *A description of the MCO's efforts to prevent, detect, and remediate critical incidents.* g. *Summary of quality committee structure and activity providing structure, at a minimum for the internal quality improvement committee that monitors the annual quality strategy and work plan; and internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies.* h. *An assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance.* i. *An assessment of the quality and appropriateness of care furnished to members with special health care needs, with a report of aggregate data indicating the number of members identified and methods used to evaluate the need for direct access to specialists.* j. *A demonstration of improvement in an area of poor performance in care coordination for members with special health care needs and behavioral conditions.* k. *A report on the member grievance and appeal system.* l. *Monitoring and enforcement of consumer rights and protections that ensures consistent response to complaints of violations of consumer rights and protections.* Contract 7.9.4.9.3; 7.9.4.9.3.1-7.9.4.9.3.11		
MCO Description of Process:		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the contract effective January 2022 included additional QAPI evaluation requirements which will be evaluated during future compliance reviews.		
Required Actions: None.		
42. *The MCO's evaluation also includes:* a. *How the MCO will incorporate the results in its quality improvement strategy.* b. *How the MCO plans to update its quality improvement strategy based on the findings of the self-evaluation.* Contract 7.9.4.9.5.1-7.9.4.9.5.2	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** 2021 QM PE, Pg 2 Secs Intro & Exec Summary	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the requirements for this element were not applicable for the time period under review. Of note, the contract effective January 2022 included these additional QAPI evaluation requirements, which will be assessed during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program						
Met	=	38	X	1	=	38
Not Met	=	1	X	0	=	0
Not Applicable	=	3				
Total Applicable	=	39	**Total Score**		=	38
Total Score ÷ Total Applicable					=	97%

Appendix B. Compliance Review Corrective Action Plan

SFY 2021–22 Compliance With Standards Review Tool CAP Template

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
General Rules			
42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.*	**Evidence as Submitted by the MCO:** • Policy 1 Credentialing Program Structure, Page 3, sections ii. and iii.; Page 4, section iv. • Policy 2 Credentialing Program Provider Scope, Pages 1-5 • Policy 3 Credentials Committee, Page 1, section 2i.-ii. • Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 1, section 2.A., Pages 3-19, section 5. • Policy 4.0.1 BH - Education Criteria, Page 1, section 2; Pages 3-8, section 5. • Policy 4.0.2 Cred NP, CNM and PA, Page 1, section 2; Pages 3-10, section 5. • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery	☐ Met ☒ Not Met ☐ NA

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

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
		Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 5 Initial Application, Page 1, section 2; Pages 2-10, section 5. • Policy 6 Process for Verification of Data Elements, pages 2-5, section 5 • Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Additional State Specific Regulatory or Contractual Requirements for Nevada, entire policy - Caqh.org - Uniform Credentialing - Nevada Division of Insurance	
	MCO Description of Process: Written credentialing policies and procedures describe the scope, criteria, timeliness, specific procedures for conducting credentialing and recredentialing of providers and how credentialing information is received, stored, reviewed, tracked and dated. These established policies and procedures help to ensure quality of care. The credentialing process utilizes the Uniform Credentialing/Recredentialing Provider Application through the CAQH Universal Provider Data source to capture all required data and is compliant with NCQA and consistent with DHCFP requirements. The NV Credentials Committee is supported by the Credentialing department, which conducts all verifications and credential file preparation. The Additional State Specific Regulatory or Contractual Requirements for Nevada policy identifies any state specific or contractual requirements for a particular state as it relates to the credentialing and recredentialing processes. This policy is designed to be used in conjunction with the core Credentialing policies. State specific regulatory and contractual requirements		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	take precedent over the requirements of the core credentialing policies for those lines of businesses affected by the state specific regulatory or contractual requirements. Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required DHCFP information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant's training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with DHCFP and any regulations thereunder or, if located in a jurisdiction outside of Nevada in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices. The credentialing requirements meet and exceed NCQA standards, providing an excellent framework to assess the clinical competence of each credentialed provider and ensure standards are applied consistently. Site visits are conducted for any facility that is not accredited or have a Medicare survey or that is identified on the Health Resources and Services Administration shortage designation list. Credentialing policies and procedures comply with NCQA, state, and federal laws and regulations, including 42 CFR 438.214 and 42 CFR 1002.3.		
	HSAG Findings: The MCO's policy listed practitioners who were not subject to professional conduct and competency review under the MCO's credentialing program but were subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services. These practitioners included: • Certified behavioral analysts. • Certified addiction counselors. • Substance abuse practitioners. The MCO's policy also listed multiple Health Delivery Organizations (HDOs) that were not subject to professional conduct and competence review under the MCO's credentialing program but were subject to a certification requirement process. These HDOs included: • Clinical laboratories.		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	• End Stage Renal Disease (ESRD) service providers. • Portable x-ray suppliers. • Home Infusion Therapy when associated with another currently credentialed HDO. • Hospice. • Federally Qualified Health Centers (FQHCs). • Rural Health Clinics (RHCs). MCO staff members explained that an abbreviated credentialing process would occur and that ancillary HDOs would be handled by a different team who would verify the credentials of these providers. However, in review of the MCO's contract with DHCFP, Section 7.6.2.3 of this contract requires the MCO to credential and recredential providers seeking network provider status with the MCO. Therefore, all providers who have network status with the MCO, and who would be displayed as a network provider in the provider directory, must complete the MCO's formal credentialing process.		
	Required Actions: The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorder (SUD), and LTSS providers. If State regulations or provider licensure laws conflict with NCQA standards, State regulations and provider licensure laws control for the credentialing process.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
File Reviews			
42 CFR §438.214 Contract 7.6.2.3.4	10. The MCO complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool.	**Evidence as Submitted by the MCO:** • Policy 2 Credentialing Program Provider Scope, Pages 1-5 • Policy 3 Credentials Committee, Page 1, section 2i.-ii. • Policy 6 Process for Verification of Data Elements, Pages 2-10 • Policy 6.1 Distribution of Appropriate Information Related to Practitioner Education_Training_Certification • Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Caqh.org • Uniform Credentialing - Nevada Division of Insurance • Nevada Process – Quality of Care-Adverse Events Review.pdf • Quality of Care – Core Procedure.pdf	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: All applicable Practitioners and Health Delivery Organizations (HDOs) are required to be re-credentialed at least every three (3) years, unless otherwise required by contract or state regulations. The re-credentialing process incorporates re-verification and identification of changes in the provider's licensure, sanctions, certification, health status and/or performance information (including but not limited to malpractice experience, hospital privilege or other actions) that may reflect upon the providers' professional conduct and competence.		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The Credentialing Program Provider Scope policy defines the categories of Providers requiring credentialing, re-credentialing, and ongoing monitoring so as to assess whether the healthcare Providers participating in the provider network(s) meet standards of professional conduct and competence, which may be determined through Credentials committee review; or in specific situations, based upon actions taken regarding the Provider's licensure or participation in government programs such as Medicare, Medicaid or the Federal Employee Health Benefits Program (FEHBP). The Credentials Committee (Geographic) policy establishes the responsibilities of the geographic Credentials Committee (CC) and provides a consistent methodology to review and make credentialing decisions for those providers initially applying for participation, and those reviewed for continued participation, in one or more of the programs or Provider network(s). The Process for Verification of Data Elements policy identifies those elements and the procedures required to be verified by the credentialing department during the credentialing or re-credentialing process for applicants that are applying for initial participation or continued participation. Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The Distribution of Appropriate Information Related to Practitioner Education, Training and Certification outlines the manner in which data received, verified and assessed in the credentialing process is managed so as to maintain its integrity. Additionally, the policy provides mechanisms to support that practitioner information made available to members is consistent with that which has been obtained from practitioner and verified through the credentialing process. This policy specifically addresses information related to practitioner education, training, certification and specialty. The Re-credentialing policy defines the process, time frame and procedures required for re-credentialing practitioners and Health Delivery Organizations (HDOs) in provider network(s). The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient.		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The Quality of Care policy is to ensure quality and appropriateness of care rendered by monitoring for potential or identified Quality of Care (QOC) issues on an on-going basis.		
	HSAG Findings: The case file review identified one recredentialing file in which the provider was identified as being excluded from participation in a State/federal government program, and a termination letter sent to the provider dated June 7, 2022, indicated that the provider was excluded since September 20, 2020. The credentialing file also included documentation that confirmed the provider was listed on the Preclusion List, yet the provider was approved for participation. This demonstrated that the MCO included this provider in its network for over 20 months after the provider was excluded and also indicated a gap in the MCO's ongoing monitoring of provider sanctions and exclusions. After the site review, the MCO explained that this provider was credentialed for its LOB and not Nevada Medicaid. HSAG requested proof of this statement and in follow-up, the MCO submitted a document that demonstrated the provider was terminated from the Nevada Medicaid network effective June 10, 2021 for failing to revalidate Medicaid enrollment with the State. The MCO also clarified that updating its credentialing data with this information was missed. Further, while the provider was termed from the Medicaid LOB effective June 10, 2021, the credentialing case file confirmed that the provider was excluded since September 20, 2020; therefore, the provider had been a provider for the MCO's Medicaid LOB for a period of almost nine months while being excluded from Medicare/Medicaid participation. As the MCO's credentialing database was not updated with the termination and the credentialing file indicated that the provider was approved on April 14, 2022, for various networks, including Nevada Medicaid, the provider appears to have been a provider for the MCO's Nevada Medicaid LOB until June 7, 2022. **Recommendations:** As the findings for this element suggest a potential serious concern in the MCO's process for monitoring for Medicare/Medicaid exclusions at the time of credentialing and on an ongoing basis, HSAG recommends that the MCO conduct a comprehensive review of its credentialing processes to determine if this case was an anomaly or whether a more serious breach in the MCO's process occurred. Additionally, the checklists in the recredentialing case files confirmed that a performance review of "Member Satisfaction/Member Complaints" and "Quality/UM/Grievance Issues" occurred; however, the MCO's policies lacked specific details on the thresholds, data sources reviewed, and the process for querying this information at the time of recredentialing. As such, HSAG recommends that the MCO update its policies, procedures, and/or workflows to clearly outline this process. The MCO should also be prepared to demonstrate a walk-through of the credentialing specialist's (and/or other applicable staff) process, including the data queried at the time of recredentialing during future compliance reviews. Implementation of these recommendations will be evaluated during future compliance reviews.		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must comply with individual practitioner credentialing requirements as required by its contract with DHCFP.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
File Reviews			
42 CFR §438.214	11. The MCO complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool.	**Evidence as Submitted by the MCO:** • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 5 Initial Application, Page 1, section 2; Pages 2-10, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5. • Template welcome letter_Medicaid only	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Professional Competence and Conduct Criteria – Health Delivery Organizations policy establishes eligibility criteria regarding professional conduct and competence for Health Delivery Organizations (HDOs) and the HDO's participation in the program or provider network(s). This policy also defines the process and standards by which HDOs within the scope of the Company's credentialing program are initially assessed for participating in the Company provider network(s). The credentialing of Health Delivery Organizations (HDOs) is an important component of the quality management process. This process is utilized to monitor that all cred in scope organizations contracted with to provide services to NV members are qualified to perform those services and deliver the best possible care. Each HDO has a standard unique health identifier. Systems, associates, and policies and procedures are in place to accurately and timely credential and re-credential the full spectrum of physical and behavioral health providers in compliance with the DHCFP requirements. The Initial Application policy identifies the required elements and the procedures around obtaining a complete application to be completed by a Practitioner or Health Delivery Organization (HDO) applying for initial participation. The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient.		
	HSAG Findings: The case file review identified one record in which the Preclusion List and the System for Award Management (SAM) queries occurred after the credentialing decision date. HSAG requested follow-up to this finding; after the site review, the MCO confirmed it had no additional documentation to submit. **Recommendations:** While disclosure of ownership and control interest forms were included in the credentialing files, the files did not include verification that any disclosed individuals and entities were also screened for Medicare and Medicaid sanctions. MCO staff members explained that these checks are the responsibility of a different team outside of credentialing. As such, HSAG recommends that the MCO be prepared to demonstrate this process during future compliance reviews.		
	Required Actions: The MCO must credential all organizational provider types applying for provider network status in accordance with the MCO's contract with DHCFP. All verifications must occur prior to the credentialing decision.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
File Reviews			
42 CFR §438.214	12. The MCO complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool.	**Evidence as Submitted by the MCO:** • Policy 4.1 Professional Competence and Conduct Criteria - Health Delivery Organizations (HDOs), Page 1, section 2; Pages 3-9, section 5. • Policy 9 Re-credentialing, Page 1, section 2; Pages 2-13, section 5. • Policy 10 Termination and Immediate Termination, Pages 1-2, section 2; Pages 4-6, section 5.	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Professional Competence and Conduct Criteria – Health Delivery Organizations policy establishes eligibility criteria regarding professional conduct and competence for Health Delivery Organizations (HDOs) and the HDO's participation in the program or provider network(s). This policy also defines the process and standards by which HDOs within the scope of the Company's credentialing program are initially assessed for participating in the Company provider network(s). The credentialing of Health Delivery Organizations (HDOs) is an important component of the quality management process. This process is utilized to monitor that all cred in scope organizations contracted with to provide services to NV members are qualified to perform those services and deliver the best possible care. Each HDO has a standard unique health identifier. Systems, associates, and policies and procedures are in place to accurately and timely credential and re-credential the full spectrum of physical and behavioral health providers in compliance with the DHCFP requirements. The Re-credentialing policy defines the process, time frame and procedures required for re-credentialing practitioners and Health Delivery Organizations (HDOs) in provider network(s). The Termination and Immediate Termination policy defines the method and procedures for terminating a Practitioner's or Health Delivery Organizations (HDOs) participation in programs or provider network(s) for reasons relating to a provider's		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	failure to meet predetermined credentialing criteria, quality of care, patient safety, competence or professional conduct which affects or could adversely affect he health or welfare of a patient.		
	HSAG Findings: The case file review identified that one file for a laboratory provider only included a Clinical Laboratory Improvement Amendments (CLIA) certificate of compliance. No other information was provided; and while the CLIA was active, documentation did not include a verification date. MCO staff members explained that this provider was credentialed by the MCO's delegate. After the site review, the MCO provided an email thread between the MCO and its delegate wherein the MCO was requesting additional information related to a coversheet or evidence of an approval date, and if the delegate performed sanction monitoring on individual laboratories. The delegate explained that it performs monthly exclusion checks of employees, officers, contingent workers, contractors, vendors, and laboratories. The MCO further explained that the credentialing file is different than the typical credentialing cycle of a facility due to the unique circumstances regarding Labcorp and their owned laboratory facilities. No other information was provided, and the credentialing expectations for laboratory provider types remain unclear. Further, this provider is licensed by the Nevada Division of Public and Behavioral Health (DPBH) with a first issue date of June 6, 2022. While no documentation was provided to confirm the recredentialing date for this provider, the universe file reported the date as May 19, 2022. Therefore, the provider appeared to have been recredentialed (and initially credentialed) without the provider having a Nevada DPBH license. **Recommendations:** HSAG recommends that the MCO conduct a comprehensive review and create a crosswalk of all organizational providers and the Nevada-specific licensing requirements for those providers. The MCO must ensure all providers meet state-specific requirements during credentialing. Implementation of this recommendations will be evaluated during future compliance reviews.		
	Required Actions: The MCO must credential all organizational provider types applying for provider network status in accordance with the MCO's contract with DHCFP. The MCO must verify that each provider is in good standing with Nevada-specific regulatory bodies.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard IX—Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Notice of Privacy Practices			
45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1)(i-viii) 45 CFR §164.520(c)(1-3)	11. The MCO's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCO, and of the member's rights and the MCO's legal duties with respect to PHI. a. The MCO must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The MCO must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3).	**Evidence as Submitted by the MCO:** Notice Policy: pg1_a through r; pg3_4a_1&2 Training_Protecting Information_Everyone's Responsibility Pg 61 MF-ANV-0011-17 NV PRV HIPAA Authorization Form Member Handbook Pg 84-87, HIPAA Notice of Privacy Practices	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The MCO provides members a right to a notice describing the uses and disclosures of PHI that may be made by the MCO.		
	HSAG Findings: Although the Notice policy outlined the required content of a Notice of Privacy Practices, a review of the notice on the website indicated the following gaps: • The notice must contain the following statement as a header or otherwise prominently display, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY." The MCO's notice did not include this specific statement as required. Instead, it indicated, "Please read this notice carefully. This tells you: Who can see your protected health information(PHI). When we have to ask for your OK before we share your PHI. When we can share your PHI without your OK. What rights you have to see and change your PHI." According to the Federal Register, this is the only verbatim language covered entities must include in the notice. Please refer to https://www.federalregister.gov/documents/2000/12/28/00-32678/standards-for-privacy-of-individually-identifiable-health-information. • The notice must contain a description, including at least one example of the types of uses and disclosures that the covered entity is permitted by this subpart to make for each of the following purposes: treatment, payment, and health care operations. Although the notice included a section, "When it is OK for us to use and share your PHI," and under the header,		

Standard IX—Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	this bullet, "For payment, healthcare operations, and treatment," and statements under the bullet describing when the MCO would disclose information (e.g., "to share information with the doctors, clinics, and others who bill us for your care"), the descriptions were not tied directly to treatment, payment, or health care operations, making it challenging for a member to understand each purpose. • The notice must contain a description of the types of uses and disclosures that require an authorization under §164.508(a)(2)-(a)(4), which would include uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures that involve the sale of PHI. Although the noticed indicated, "we have to get your written OK before we share psychotherapy notes from your doctor about you," the notice did not indicate authorization is required for marketing and the sale of PHI. **Recommendations:** After reviewing the Notice of Privacy Practices published on the MCO's website, HSAG discovered that the notice indicated March 21 as the last revision date. However, the member handbook, effective January 1, 2022, included a HIPAA Notice of Privacy Practices that indicated the notice was revised January 5, 2018, implying that members did not receive the most current version of the notice. During the site review, MCO staff members indicated that this was a material change but later confirmed that none of the changes between the version on the website and the version provided to members as part of the handbook constituted a material change. However, HSAG recommends that the MCO update its member handbook to include the most current version of the Notice of Privacy Practices. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: The MCO must ensure the Notice of Privacy Practices includes all the required components as indicated in 45 CFR §164.520(b)(1)(i–viii).		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard IX—Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Timely Resolution and Notification of Grievances			
42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract 7.8.10.9.1.1; 7.8.10.11.1	7. The MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. a. The MCO must resolve the grievance and send *written* notice to the affected parties *no later than ninety (90) calendar days* from the day the MCO receives the grievance. b. *The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.* c. The notice must meet the standards described at 42 CFR §438.10 *and include the results of the resolution process and the date it was completed.*	**Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Pages 3, 5 & 6 NV Member Grievance 1st Resolution Letter NV Member Grievance 1st Resolution 2nd Level Letter NV Member Grievance 2nd Level Resolution Letter NV Member Grievance No Quality of Care Resolution Letter NV Member Grievance Quality of Care Resolution Letter	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the grievance resolution notice requirements and timeframes for all grievances in accordance with federal and Contract requirements. The grievance resolution processes for all grievances is further demonstrated and communicated in, NV Member Grievance Resolution Policy, Pages 3, 5 & 6; NV Member Grievance 1st Resolution Letter; NV Member Grievance 1st Resolution 2nd Level Letter; NV Member Grievance 2nd Level Resolution Letter; NV Member Grievance No Quality of Care Resolution and NV Member Grievance Quality of Care Resolution Letter. The Grievance File Review will also demonstrate appropriate resolution of each grievance.		
	HSAG Findings: All grievances reviewed as part of the case file review were reviewed and notice was sent within 90 calendar days. However, some cases were documented as expedited priority or required a more expeditious review than 90 days but were not completed until months later (e.g., cases 1, 5, 6, and 7). For one case (case 3), the member indicated feeling discriminated against; however, the grievance resolution notice did not explain how MCO staff members investigated the discrimination allegation. Additionally, for most of the case files, there was no evidence to demonstrate that the MCO was also making reasonable efforts to provide oral notice of the resolution of the grievance. Finally, although the grievance resolution letters		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	included a Spanish tagline with appropriate information to meet the intent of 42 CFR §438.10, it was not written in conspicuously visible font. **Recommendations:** Although the MCO indicated it considers the mailing date of the resolution notice as the date the resolution of the grievance is completed, HSAG recommends that the MCO consider adding the date of resolution within the body of the notice. Implementation of this recommendation will be evaluated during future compliance reviews. Additionally, HSAG is also making a recommendation to DHCFP to reduce the current 90-day time frame allowance.		
	Required Actions: The MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance, and the written notice must meet the standards described at 42 CFR §438.10 and include the results of the resolution process and the date it was completed.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Timely Resolution and Notification of Grievances			
42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 7.8.10.9.3	9. If the MCO extends the grievance resolution time frame not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.	**Evidence as Submitted by the MCO:** NV Member Grievance Resolution Policy, Pages 3, 5 & 6 NV Member Grievance 1st Resolution Letter NV Member Grievance 1st Resolution 2nd Level Letter NV Member Grievance 2nd Level Resolution Letter NV Member Grievance No Quality of Care Resolution Letter NV Member Grievance Quality of Care Resolution Letter	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the grievance resolution notice process regarding health plan requested extensions in accordance with federal and Contract requirements. This process is further demonstrated in the NV Member Grievance Resolution Policy, Page 6. There are no examples of grievances with extended timeframes requiring DHCFP review and approval during the audit review period.		
	HSAG Findings: Although the MCO's Member Grievance Resolution–NV policy indicated that grievance time frames may be extended by up to 14 calendar days and that the MCO will notify the member in writing within two calendar days of the reason for the extension and inform the member of the right to file a grievance, the policy did not include that the MCO will make reasonable efforts to give the member prompt oral notice of the delay when a grievance time frame is being extended. **Recommendations:** Although the MCO indicated that there were no examples of grievances with extended time frames during the time period under review, HSAG recommends that the MCO develop a grievance resolution extension notice template with grievance language to ensure the notice is readily available should the MCO ever extend the grievance resolution time frame. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: If the MCO extends the grievance resolution time frame not at the request of the member (after DHCFP approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay, and within two		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	calendar days give members written notice of the reason for the decision to extend the time frame and inform them of the right to file a grievance if they disagree with that decision.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Appeals General Requirements			
42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 7.8.10.6.1	14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If an appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. The MCO must not require the member to submit a written appeal after making an oral appeal.*	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 5 NV Member Handbook, section Medical Appeals, Page 68	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the appeal filing process regarding member consent for when a provider or representative is appealing on behalf of the member in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 5 NV Member Handbook, section Medical Appeals, Page 68. The Appeal File Review will also demonstrate method of appeal receipt handling.		
	HSAG Findings: According to the case file review, six of 10 cases did not contain evidence that the MCO obtained members' written consent for a provider or an authorized representative to request an appeal on the member's behalf. Additionally, the Appeal acknowledgement letters inaccurately informed members that the MCO needed a written appeal request within 10 days from the date of the call, and if the information is not received, the appeal would be closed. **Recommendations:** The member handbook indicated that "If you want your PCP or provider to file an appeal for you, he or she must have your written permission, unless you are asking for an expedited appeal." Although this language is in the contract, HSAG strongly recommends that the MCO remove the language stipulating there are exceptions to obtaining written permission as this does not align with federal rule. Implementation of this recommendation will be evaluated during future compliance reviews.		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must obtain the member's written consent for a provider or an authorized representative to request an appeal on behalf of the member. The MCO must not require the member to submit a written appeal after making an oral appeal.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Handling of Appeals			
42 CFR §438.406(b)(1) 42 CFR §438.410(c) 42 CFR §438.228 Contract 7.8.10.5.3	15. If the MCO denies a request for expedited resolution of an appeal, it must: a. Transfer the appeal to the time frame for standard resolution *of no longer than thirty (30) calendar days from the day the MCO receives the appeal.* b. Follow the requirements in 42 CFR §438.408(c)(2), including: i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 7 NV Member Handbook, Page 70 NV Member Appeal Expedited to Standard Ack Letter NV Appeal File OS1 Denied for Expedited Resolution, Pages 4, 6 & 49 NV Appeal File 2 Denied for Expedited Resolution, Pages 3, 4 & 22 NV Appeal File 3 Denied for Expedited Resolution, Pages 4, 15 & 31	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the appeal resolution notices and timeframes process for all appeals in accordance with federal and Contract requirements. The appeal resolution notice processes for all appeals are further demonstrated and communicated in NV Medical Necessity Appeals Policy, Page 7; NV Member Handbook, Page 70 and NV Member Appeal Expedited to Standard Ack Letter. **Three examples of a denied request for an expedited appeal resolution:** NV Appeal File OS1 (part of appeal file review), Pages 4, 6 & 49, NV Appeal File 2 Denied for Expedited Resolution, Pages 3, 4 & 22 and NV Appeal File 3 Denied for Expedited Resolution, Pages 4, 15 & 31.		
	HSAG Findings: According to the case file review, the MCO was not making reasonable efforts to give the member prompt oral notice of the delay when the MCO denied a request for expedited resolution of an appeal. Additionally, although two case		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	files did include written notice to the members, the notices did not inform the members of the right to file a grievance if they disagreed with the delay in resolving the appeals.		
	Required Actions: If the MCO denies a request for expedited resolution of an appeal, it must make reasonable efforts to give the member prompt oral notice of the delay; and within two calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Handling of Appeals			
42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	16. The MCO must acknowledge receipt of each appeal.	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 5 NV Member Appeal Acknowledgement Letter NV G&A Organizational Chart	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the appeal acknowledgement and timeframes process in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 5, NV Member Appeal Acknowledgement Letter and NV G&A Organizational Chart. The Appeal File Review will also demonstrate timely acknowledgement of each appeal.		
	HSAG Findings: For all 10 appeals reviewed as part of the case file review, acknowledgement letters were sent within five calendar days as required according to MCO policy. However, for two cases, the acknowledgement letters were addressed to the providers. Members did not receive the acknowledgement letters as required. Additionally, one case was for an expedited appeal, but the acknowledgement letter indicated that the appeal would be resolved in 30 days instead of 72 hours as required. Further, one case was filed by an adult member, but the acknowledgement letter was addressed to "Parent/Guardian of …."		
	Required Actions: The MCO must acknowledge receipt of each appeal, and the acknowledgement must be provided to the member.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(b)(3) 42 CFR §438.228 Contract 7.8.10.9.1.3; 7.8.10.11.1	22. The MCO must resolve expedited appeals and send *written* notice to the affected parties no later than seventy-two (72) hours after the MCO receives the appeal. a. *The MCO is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.*	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 7 NV Member Appeal Upheld Letter	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the expedited appeal resolution written notice timeframes and process for all appeals in accordance with federal and Contract requirements. The appeal resolution processes is further demonstrated and communicated in NV Medical Necessity Appeals Policy, Page 7 and NV Member Appeal Upheld Letter.		
	HSAG Findings: According to the case file review, one expedited appeal case was not resolved within the 72-hour time frame. There was also no evidence to support that the member was notified orally of the decision.		
	Required Actions: The MCO must resolve expedited appeals and send written notice to the affected parties no later than 72 hours after the MCO receives the appeal.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(c)(2) 42 CFR §438.228 Contract 7.8.10.9.3	24. If the MCO extends the standard or expedited appeal resolution time frames not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 6	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the appeal resolution notice timeframes and process regarding health plan requested extensions, in accordance with federal and Contract requirements. This is further demonstrated in the NV Medical Necessity Appeals Policy, Page 6. There are no examples of appeals with extended timeframes requiring DHCFP review and approval during the audit review period.		
	HSAG Findings: Although the NV Medical Necessity Appeals policy indicated time frames may be extended by up to 14 calendar days, and that the MCO will notify the member in writing within two calendar days of the reason for the extension and inform the member of the right to file a grievance, the policy did not include that the MCO will make reasonable efforts to give the member prompt oral notice of the delay when an appeal time frame is being extended. **Recommendations:** Although the MCO indicated that there were no examples of appeals with extended time frames during the time period under review, HSAG recommends that the MCO develop an appeal resolution extension notice template with		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	grievance language to ensure the notice is readily available should the MCO ever extend the appeal resolution time frame. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: If the MCO extends the standard or expedited appeal resolution time frames not at the request of the member (after DHCFP approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay, within two calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision; and resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228	26. For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal.	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Pages 6-7 NV Member Appeal Upheld Letter NV Member Appeal Overturn Letter	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the appeal resolution written notices process and next level rights for all upheld appeals, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Pages 6-7, NV Member Appeal Upheld Letter and NV Member Appeal Overturn Letter. The Appeal File Review will also demonstrate appropriate resolution and next level rights.		
	HSAG Findings: Although the MCO's policy indicated that the member will always be provided written notification of the appeal determination regardless of who initiates the appeal, according to the case file review findings, one appeal resolution notice was sent to the provider and not to the member.		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Additionally, although the English tagline was in conspicuous font, the Spanish tagline was not. Although some letters had a bold statement in the beginning of the letter in Spanish indicating, "This letter is about your benefits. If you have questions or need it in Spanish, call…," there was no information on how to request auxiliary aids and services in conspicuous font as required by 42 CFR §438.10. Further, although a tagline sheet was included in the letter, which appears to be in larger font, it only indicated that translation is available at no cost. It did not indicate that other formats are available. Finally, according to the contract with DHCFP currently in effect, the time frame for members to file a SFH is 120 days. For one appeal reviewed as part of the case file review (case 7), the member's denial was upheld; however, the member was not provided with SFH rights. **Recommendations**: The MCO's continuation of benefits language indicated that "if a final decision is made in favor of Anthem, you must pay for all charges during the time of your appeal or fair hearing." HSAG recommends that the MCO consider whether "must" should be updated to "may" if the MCO will not always require the member to pay back the charges for the services obtained during the appeal. Further, as indicated through the case file review, some resolution notices included acronyms that were not spelled out and minor typographical or grammatical errors. As such, HSAG recommends that the MCO ensure it has a quality assurance process to review resolution notices prior to the notices being sent to members. The MCO may also want to consider developing specific template language for appeals that relate to durable medical equipment (DME) to ensure that the template language makes sense with the type of service being appealed. Implementation of these recommendations will be evaluated during future compliance reviews.		
	Required Actions: For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution must include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member, the written notice of resolution must also include the right and how to request a SFH, and the right and how to request and receive benefits while the hearing is pending. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal must also be included.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 7.8.10.11.1	27. For notice of a *standard* and expedited appeal resolution, the MCO is *required to make a good faith effort* to provide oral notice *of the disposition in addition to the required written notice*.	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 74 NV Appeal File Review 6 Oral Notice for Expedited Resolution, Page 74 NV Appeal File 2 Oral Notice for Expedited Resolution, Pages 1, 4 & 22 NV Appeal File 3 Oral Notice for Expedited Resolution, Pages 1, 5 & 23	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the expedited appeal resolution notice timeframes, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 74. **Three examples of oral notice for an expedited appeal resolution:** NV Appeal File Review 6 Oral Notice for Expedited Resolution, Page 7 (part of appeal file review), NV Appeal File 2 Oral Notice for Expedited Resolution, Pages 1, 4 & 22 and NV Appeal File 3 Oral Notice for Expedited Resolution, Pages 1, 5 & 23.		
	HSAG Findings: The results of the case file review indicated that the MCO was not making a good faith effort to provide members with oral notice of the appeal resolution.		
	Required Actions: For notice of a standard and expedited appeal resolution, the MCO must make a good faith effort to provide oral notice of the disposition in addition to the required written notice.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
State Fair Hearings			
42 CFR §438.408(f)(2) 42 CFR §438.228 Contract 7.8.10.12.1; 7.8.10.12.2	29. *The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the MCO's notice of resolution of the appeal.* a. *The MCO is required to inform the member of their right to a SFH, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(a)(6) and 42 CFR §438.408(e)(2)(i).*	**Evidence as Submitted by the MCO:** NV Medical Necessity Appeals Policy, Page 8 NV Member Handbook, Page 70 NV Member Provider Initial Denial Upheld Letter NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Anthem G&A follows the SFH uphold timeframes and notification of member rights to a SFH, in accordance with federal and Contract requirements. This is further demonstrated and communicated in the NV Medical Necessity Appeals Policy, Page 8, NV Member Handbook, Page 70, NV Member Provider Initial Denial Upheld Letter and NV Member Appeals Rights Enclosure for Initial Denial Upheld Letter.		
	HSAG Findings: The case file review indicated that members were notified that they must request SFH rights within 120 days of the appeal notice, and not 90 days as required by the current MCO/DHCFP contract. The member handbook and Medical Necessity Appeals – NV policy also inaccurately indicated the member has 120 calendar days from the date of the appeal denial letter to file a SFH. In follow-up to the site review, the MCO indicated that the state fiscal year (SFY) 2019 compliance review tool included 120 days for members to file a SFH. Please note that this time frame aligned with the final Medicaid managed care rule published May 6, 2016 (refer to https://www.law.cornell.edu/rio/citation/81_FR_27853), during this time period under review. However, the final Medicaid managed care rule was amended on November 13, 2020, and the time frame for requesting a SFH was updated to allow states to stipulate hearing time frames to "no less than 90 calendar days and no greater than 120		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution." According to the federal register at https://www.law.cornell.edu/rio/citation/85_FR_72842: **Resolution and Notification: Grievances and Appeals (§ 438.408)** We proposed a revision to § 438.408(f)(2) to require the timeframe for an enrollee to request a state fair hearing after receiving an adverse decision from a managed care plan would be no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution; under this proposal, the state would set the specific deadline within these limits. Previously, in the 2016 final rule, we revised the timeframe for managed care enrollees to request a state fair hearing to 120 calendar days from a plan's decision; this was codified at § 438.408(f)(2). We adopted this timeframe because we believed it would give enrollees more time to gather the necessary information, seek assistance for the state fair hearing process, and make the request for a state fair hearing (81 FR 27516). However, we have heard from stakeholders that the 120-calendar day requirement has created an inconsistency in filing timeframes between Medicaid FFS and managed care, creating administrative burdens for states and confusion for enrollees. The FFS rule limits the timeframe beneficiaries have to request a hearing to no more than 90 days (§ 431.221(d)). It was not our intent to burden states with additional tracking of the fair hearing process in multiple systems, on multiple timeframes. Nor do we want to confuse enrollees in states where some services are provided through FFS and others through managed care. Therefore, we proposed to revise § 438.408(f)(2) to stipulate that the timeframe for enrollees to request a state fair hearing will be no less than 90 calendar days and no greater than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution. We stated the proposed revision would allow states that wished to align managed care with the FFS filing timeframe to do so without jeopardizing the enrollee's ability to gather information and prepare for a state hearing. This proposal would also allow states that have already implemented the 120-calendar day timeframe to maintain that timeframe without the need for additional changes. Although RFP 3260 (historical contract) originally indicated that members had 90 days to file a SFH, RFP 3260 was later amended to comply with the 120 days required under federal regulations. However, with the allowance under the 2020 final		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Medicaid managed care rule, DHCFP updated language within RFP S1457 (contract effective during the review period) to 90 days to coincide with the revised allowances under federal rule for SFH time frame requirements. The MCO must ensure that it reviews each version of its contract with DHCFP and make timely updates to policies, procedures, and member materials to accurately reflect all contract revisions.		
	Required Actions: The MCO must ensure that the member submits a request for a SFH in writing within 90 calendar days from the date of the MCO's notice of resolution of the appeal. The MCO is required to inform the member of the right to a SFH, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO pursuant to 42 CFR §431.200(b), 42 CFR §431.220(a)(6), and 42 CFR §438.408(e)(2)(i).		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Critical Incident Management System			
Contract 7.9.14.4; 7.9.14.4.1-7.9.14.4.5	29. *The MCO submits follow-up reports using the Incident Reporting System and closes the case within forty-five (45) calendar days after the critical incident was initially reported. A case cannot be closed until the following information is provided:* a. *A summary of any debriefings.* b. *Whether the member is in custody (jail), in the hospital, or in the community.* c. *Whether the member is receiving services and include the types of services provided.* d. *If the member cannot be located, the steps the MCO has taken to locate the member using available, local resources.* e. *In the case of the death of a member, verification from official sources that includes the date, name, and title of the sources. When official verification cannot be made, the MCO must document all attempts to retrieve it.*	**Evidence as Submitted by the MCO:** Item 24 NV Critical Incident Reporting Procedure 202 QI PD CIR process_v3	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Anthem Blue Cross and Blue Shield Healthcare Solutions plan acknowledges that the critical incidents that were identified have not had resolution within 45 days of reporting. This process will need to be refined and instituted with the Interim Director and then reviewed, dissected, and improved upon identification and hiring of our new Director of Quality Improvement. The team acknowledges this gap and will begin refinement immediately. An internal corrective action plan will be created and initiated within 30 days.		
	HSAG Findings: The MCO did not submit follow-up reports using the Incident Reporting System and close the case within 45 calendar days after the critical incident was initially reported as required in the contract. During the site review, MCO staff members acknowledged this gap and explained that the MCO is implementing corrective action.		

Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must ensure that it submits follow-up reports using the Incident Reporting System, closes the case within 45 calendar days after the critical incident was initially reported, and ensure the follow-up information required by sub-elements (a) through (e) are included, as applicable.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted