State of Nevada

Division of Health Care Financing and Policy

FY 2014-2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance

for

Health Plan of Nevada

March 2015

HSAG Health Services Advisory Group

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CONTENTS

1. Executive Summary
for Health Plan of Nevada

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

The purpose of the fiscal year (FY) 2014–2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance was to determine **Health Plan of Nevada** (**HPN**'s) compliance with federal and the State's managed care standards. For the FY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed **HPN**'s managed care and quality program activities that occurred during FY 2013–2014. HSAG reviewed **HPN**'s compliance with the following:

- State and federal managed care requirements, which were categorized into 14 contract standards, referred to as ***IQAP Standards***
- Outreach and educational materials associated with member rights and responsibilities, member handbook, medical record standards, and the provider manual, referred to as ***Checklists***
- Operational compliance for credentialing, recredentialing, service denial, grievances, and appeal processing activities, referred to as ***File Reviews***

HPN had a composite score of 98.6 percent for all elements evaluated in the FY 2014-2015 IQAP Compliance Review. With a couple of exceptions noted in this report, **HPN** demonstrated strong compliance with the federal and State requirements contained in its managed care contract. Figure 1 summarizes the overall ratings for **HPN**'s IQAP Standards, Checklists, and File Reviews for the FY 2014-2015 IQAP Compliance Review.

Figure 1 presents the combined overall rating for **HPN**.

Figure 1—Overall Rating for HPN	
IQAP Standards Score	For the IQAP Standards, **HPN** received a total score of **97.3%**.
Checklist Score	For the Checklist review, **HPN** received a total score of **98.7%**.
File Review Score	For the File Review, **HPN** received a total score of **99.1%**.
Overall Score	**HPN** received an overall rating of **98.6%** for all elements reviewed in the FY 2014–2015 IQAP Compliance Review.

2. Background
for Health Plan of Nevada

Overview

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

According to the 42nd Code of Federal Regulations (CFR) 438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438. To meet this requirement, DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Health Plan of Nevada (HPN**). According to the federal requirements, the quality of health care delivered to Medicaid recipients enrolled in MCOs must be tracked, analyzed, and reported annually. Oversight activities of the EQRO focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid and Nevada Check Up beneficiaries.

Purpose of the Review

The purpose of the fiscal year (FY) 2014–2015 Internal Quality Assurance Program (IQAP)[1-1] On-Site Review of Compliance was to determine **HPN**'s compliance with federal and the State's managed care standards. In addition, HSAG conducted a review of individual files for the areas of credentialing, recredentialing, grievances, appeals, denials, and case management services to evaluate **HPN**'s implementation of the standards. Checklist reviews validated that the managed care organization (MCO) informed members of their rights and responsibilities and other required information in the member handbook. Checklists also confirmed that **HPN** apprised providers of the medical records standards and additional required information in the provider manual. For the FY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed **HPN**'s quality program activities that occurred during the review period, which was July 1, 2013–June 30, 2014 (i.e., FY 2013–2014).

[1-1] The internal quality assurance program (IQAP) is a strategy consisting of systematic quality improvement activities to ensure an ongoing quality assessment and performance improvement (QAPI) program for services furnished to recipients.

3. Methodology
for Health Plan of Nevada

Compliance Review Process

The IQAP standards were derived from the requirements as set forth in the Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 1988 for Managed Care, and all attachments and amendments in effect during FY 2013–2014. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[1-2] to create the process, tools, and interview questions used for the FY 2014–2015 Compliance Review.

Methods for Data Collection

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

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the 2-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate its preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP, and of documents each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample cases plus an oversample of 5 cases for each of the following file reviews: grievances, appeals, denials, credentialing, recredentialing, and case management.

On-site review activities included**:**

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By- Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

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

HSAG documented its findings in the data collection (compliance review) tool shown in Appendix A, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant. The results for the IQAP standards are noted in Table 2 of this report. The results for checklists and file reviews are summarized in Table 3 and Table 4, respectively, in the pages that follow.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created the Corrective Action Plan (CAP) template, shown in Appendix B, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to DHCFP, **HPN** must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **HPN** must submit its CAP to DHCFP **within 21 days of receiving this report.**

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers/subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included, but were not limited to: utilization management, quality management, care management and coordination, health management and service authorization, credentialing, cultural competency, delegation and contracting, and member education.
- MCO-maintained files for member grievances and appeals, denials of services, case management, and practitioner credentialing and recredentialing.
- MCO questionnaire.

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

IQAP Standards, Checklists, and Files Reviewed

Table 1 lists the standards reviewed and associated checklists or files reviewed as evidence of compliance with internal policies.

Table 1: IQAP Standards, Checklists, and File Reviews		
IQAP Standard Number	IQAP Standard Name	Number of Elements
I	Internal Quality Assurance Program	54
II	Credentialing and Recredentialing	16
III	Member Rights and Responsibilities	14
IV	Member Information	14
V	Availability and Accessibility of Services	28
VI	Continuity and Coordination of Care	16
VII	Grievances and Appeals	35
VIII	Subcontracts and Delegation	13
IX	Cultural Competency Program	16
X	Coverage and Authorization of Services	23
XI	Provider Dispute and Complaint Resolution	9
XII	Confidentiality and Record Keeping	9
XIII	Provider Information	3
XIV	Enrollment/Disenrollment	11
	Total Number of IQAP Elements	261
Associated IQAP Standard #	Checklist Name	Number of Elements
III	Member Rights and Responsibilities	9
IV	Member Handbook	34
XII	Medical Record Standards	26
XIII	Provider Manual	10
	Total Number of Checklist Elements	79
Associated IQAP Standard #	File Review Name	Number of Elements
II	Initial Credentialing	162
II	Recredentialing	207
VII	Grievances	30
VII	Appeals	39
VII	Denials	30
VI	Case Management	177
	Total Number of File Review Elements	645

Data Aggregation and Analysis

IQAP Standards

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

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

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the 14 IQAP standards and an overall percentage-of-compliance score across the 14 IQAP standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.5 point), and *Not Met* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

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

Checklists

For the Checklists reviewed, HSAG surveyors scored each applicable element within the checklists as either *Yes*, the element was contained within the associated document, or *No*, the element was not contained within the document. Elements that were not applicable to the MCO were scored as *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage

score, HSAG added the total number of elements that received a *Yes* score and divided it by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for credentialing, recredentialing, grievances, appeals, denials, and case management to verify that the MCO has put into practice what the MCO documented in its policy. HSAG randomly selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all of the MCO's files. Rather, the file review highlighted when practices described in policy were not followed by MCO staff. Based on the results of the file reviews, the MCO must determine if any areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred.

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

Aggregating the Scores

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

- Documented findings describing the MCOs' performance in complying with each of the IQAP standard requirements.
- Scores assigned to the MCOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the 14 IQAP standards.
- The overall percentage-of-compliance score calculated across the 14 IQAP standards.
- The overall percentage-of-compliance score calculated for each of the file reviews.
- The overall percentage-of-compliance score calculated for each of the checklists.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

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

4. IQAP Findings
for Health Plan of Nevada

Evaluation Ratings for HPN

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

Table 2 presents **HPN**'s scores for the IQAP standards. Details regarding **HPN**'s compliance with the 14 IQAP standards, including the score **HPN** received for each of the elements in each standard, can be found in Appendix A, IQAP FY 2014–2015 Compliance Review Tool for **HPN.**

Table 2—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
I	Internal Quality Assurance Program	**54**	54	53	1	0	0	**99.1%**
II	Credentialing and Recredentialing	**16**	15	15	0	0	1	**100.0%**
III	Member Rights and Responsibilities	**14**	14	13	1	0	0	**96.4%**
IV	Member Information	**14**	14	14	0	0	0	**100.0%**
V	Availability and Accessibility of Services	**28**	28	27	1	0	0	**98.2%**
VI	Continuity and Coordination of Care	**16**	16	16	0	0	0	**100.0%**
VII	Grievances and Appeals	**35**	35	31	3	1	0	**92.9%**
VIII	Subcontracts and Delegation	**13**	12	10	2	0	1	**91.7%**
IX	Cultural Competency Program	**16**	16	14	2	0	0	**93.8%**
X	Coverage and Authorization of Services	**23**	23	23	0	0	0	**100.0%**
XI	Provider Dispute and Complaint Resolution	**9**	9	9	0	0	0	**100.0%**
XII	Confidentiality and Record Keeping	**9**	9	8	1	0	0	**94.4%**
XIII	Provider Information	**3**	3	3	0	0	0	**100.0%**
XIV	Enrollment/Disenrollment	**11**	11	10	1	0	0	**95.5%**
	Total Compliance Score	**261**	**259**	**246**	**12**	**1**	**2**	**97.3%**

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

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

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

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

A review of the IQAP standards show how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. Of the 259 applicable elements, **HPN** received a *Met* for 246 elements, a *Partially Met* for 12 elements, and a *Not Met* for 1 element. The findings suggest that,

with a few exceptions, **HPN** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate its compliance with the contract. Further, interviews with **HPN** staff showed that staff were knowledgeable about contract requirements and the procedures the MCO employed to meet its contractual requirements.

Table 3 presents the scores for the checklists. HSAG reviewed all requirements related to Member Rights and Responsibilities, Member Handbook, Medical Record Standards, and Provider Manual to verify that each was in compliance with State and federal requirements. HSAG scored the elements required for each of these areas via checklists. Each checklist review area was scored based on the total number of **HPN**'s compliant elements divided by the total number of applicable elements for each of the four areas reviewed.

Table 3—Summary of Scores for the Checklists

Associated IQAP Standard #	Description of File Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
III	Member Rights and Responsibilities	**9**	9	100%
IV	Member Handbook	**34**	33	97.1%
XII	Medical Record Standards	**26**	26	100%
XIII	Provider Manual	**10**	10	100%
	Checklist Totals	**79**	**78**	**98.7%**

The results generated by the checklists serve as another indicator of the MCO's development of outreach information and ensure that the information contains all contractually required elements. Of the 79 elements reviewed for the checklists, **HPN** received a score of *Met* for all 78 elements. The findings suggest that **HPN** had strong compliance with each of the areas evaluated by the checklists and **HPN** developed the necessary manuals, standards, and policies according to contract requirements. **HPN**'s member handbook did not contain the provision that if a member loses Medicaid or Check Up eligibility, the member will be auto-assigned once eligibility is restored.

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

Table 4—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Initial Credentialing	**10**	162	162	100%
II	Recredentialing	**10**	207	207	100%
VII	Grievances	**10**	30	29	96.7%
VII	Appeals	**10**	39	35	89.7%
VII	Denials	**10**	30	30	100%
VI	Case Management	**10**	177	176	99.4%
	File Review Totals	**60**	**645**	**639**	**99.1%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Of the 645 applicable elements reviewed for the file reviews, **HPN** received a score of *Met* for 639 of the elements for a total of 99.1 percent. **HPN** scored 100 percent compliant for three of the areas reviewed, Initial Credentialing, Recredentialing, and Denials. **HPN** scored 99.4 percent for Case Management and 96.7 percent for the Grievance record reviews. These results suggest that **HPN** followed the policies it developed to operationalize the required elements of its contract.

The greatest opportunity for improvement was with the Appeals record review wherein **HPN** scored 89.7 percent. The Appeals record review showed that 8 of 10 appeals were acknowledged within the required timeframe; 6 of 6 standard appeals were resolved within the required timeframe; 3 of 4 expedited appeals were resolved with the proper notice sent; and there was 1 expedited appeal that was not resolved within the required timeframe and no extension notice was sent to the member.

5. Conclusions and Recommendations
for Health Plan of Nevada

Conclusions and Recommendations

Figure 2 presents overall ratings for **HPN** for IQAP Standards, Checklists, and File Reviews, as well as the overall composite score.

Figure 2—Overall Rating for HPN	
IQAP Standards Score	For the IQAP Standards, **HPN** received a total score of **97.3%**.
Checklist Score	For the Checklist review, **HPN** received a total score of **98.7%**.
File Review Score	For the File Review, **HPN** received a total score of **99.1%**.
Overall Score	**HPN** received an overall rating of **98.6%** for all elements reviewed in the FY 2014–2015 IQAP Compliance Review.

HPN's overall results for the review of the IQAP standards in the FY 2014–2015 on-site review was 97.3 percent. In addition, **HPN** received a score of 99.1 percent for the file review, a score of 98.7 percent for the checklist review, and an overall composite score of 98.6 percent. The overall results demonstrated that, with a few exceptions, **HPN** had strong adherence to State and federal standards required by its contract with DHCFP. **HPN** developed the necessary policies, procedures, and plans to carry out the required functions of the contract and the checklists and file review results demonstrated that **HPN** staff appropriately operationalized the elements described in its policies, procedures, and plans, with a few exceptions described below.

Compliance with IQAP Standards

Of the 14 standard areas reviewed, **HPN** achieved 100 percent compliance on 6 standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Credentialing and Recredentialing, Member Information, Continuity and Coordination of Care, Coverage and Authorization of Services, Provider Dispute and Complaint Resolution, and Provider Information.

The following standards achieved at least 91 percent or higher for all elements contained in the standards: Internal Quality Assurance Program, Member Rights and Responsibilities, Availability and Accessibility of Services, Grievances and Appeals, Subcontracts and Delegation, Cultural Competency Program, Confidentiality and Record Keeping, and Enrollment/Disenrollment.

- HSAG recommends that **HPN** prioritizes improvement efforts to address *Partially Met* and *Not Met* elements that were found in the standards that did not achieve 100 percent compliance with all elements. These elements must be addressed in **HPN**'s Corrective Action Plan (Appendix B), which is described in the Corrective Action Plan section of this report.

Compliance with File Review

HPN achieved 100 percent compliance on the Initial Credentialing and Recredentialing file reviews, which demonstrated the MCO's strong compliance with the credentialing and recredentialing standards. **HPN** also received 100 percent compliance for all required elements related to the file review for service Denials. All files reviewed demonstrated **HPN**'s compliance with the standards related to notices of decision when the MCO denied a service.

HPN received a 89.7 percent score for the Appeal file review. The Appeal file review showed that 8 of 10 appeals were acknowledged within the required timeframe; 6 of 6 standard appeals were resolved within the required timeframe; 3 of 4 expedited appeals were resolved with the proper notice sent; and for the 1 expedited appeal which was not resolved within the required timeframe, no extension notice was sent to the member. The Appeal file review did show that all appeal decisions were made by staff with the appropriate clinical expertise and who were not involved in the original decision to deny services.

- HSAG recommends that **HPN** determine if areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred. Further, **HPN** must acknowledge appeals within the timeframes specified by its policy. For expedited appeals, the MCO must ensure that a notice of extension is sent to members when the MCO requires more time to resolve the expedited appeal and that the expedited appeal is resolved within the required timeframes specified by the MCO's policy.

HPN received a 96.7 percent score for Grievance file review. The Grievance file review showed that 9 of 10 grievances were acknowledged within the required timeframe; all grievances were resolved within the required timeframe; and all grievances were reviewed and decisions were made by staff with appropriate clinical expertise.

- HSAG recommends that **HPN** determine if areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred. Further, **HPN** must ensure that grievances are acknowledged within the timeframes specified by its policy.

HPN achieved 99.4 percent compliance on the case management file review. **HPN** had strong adherence to the contractual requirements for identification and performing and documenting a comprehensive health risk assessment. In one file, the assessment was performed outside of the timeframe. All of the files reviewed showed that **HPN** had developed and documented a comprehensive case management plan, which included evidence that disease-specific health education materials were sent to the member. **HPN** met all of the requirements evaluated for reassessment of the care management plan. Further, the **HPN** case management files showed that **HPN** case managers evaluated members' barriers to achieve members' goals and worked with members to overcome those barriers.

- HSAG recommends that **HPN** complete comprehensive assessments of members within 90 days of enrollment.

Compliance with Checklists

HPN achieved 98.7 percent compliance for the checklist review, wherein **HPN** received a *Not Met* for one element related to the member handbook. Overall, **HPN**'s results for checklists

demonstrated strong compliance with the requirements for information included in the member rights and responsibilities, the member handbook, medical record standards, and the provider manual.

6. Corrective Action Plan
for **Health Plan of Nevada**

Corrective Action Plan

Appendix B contains the Corrective Action Plan (CAP) template HSAG prepared for **HPN** to use in preparing its CAP to be submitted to DHCFP. The template lists each of the elements for which HSAG assigned a score of *Partially Met* or *Not Met*, and the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. **HPN** must use this template to submit its corrective action plan to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **HPN**'s CAP must be submitted to DHCFP **no later than 21 calendar days after receipt of this report**.

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

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

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