Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2019–2020 Compliance Review

for

Health Plan of Nevada

October 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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

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

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

HPN had an overall compliance score of 100 percent for all elements evaluated in the SFY 2019–2020 Compliance Review. Additionally, eight out of eight CAP elements were determined to be complete, indicating these prior deficiencies were remediated. Based on the findings of the review, **HPN** demonstrated strong compliance with the federal and State requirements contained in its managed care contract.

2. Background

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

Mandatory Activity

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

Table 2-1—Nevada Compliance Review Cycle for HPN

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

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

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

Purpose of the Review

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

3. Methodology

Compliance Review Process

The compliance standards were derived from the requirements as set forth in the *Department of Health and Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period of July 1, 2019, through December 31, 2019. HSAG followed the guidelines set forth in CMS' *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[3-1] to create the process, tools, and interview questions used for the SFY 2019–2020 Compliance Review.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between the DHCFP and the MCOs. HSAG conducted the following activities as part of the compliance review:

Pre-review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Developing the managed care entity (MCE) questionnaire.
- Conducting a technical assistance session to assist the MCO in preparing for the compliance review.
- Scheduling the review.
- Developing the agenda for the review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents that each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the virtual review.

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

Virtual review activities included:[3-2]

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

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

Post review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers and subcontractors.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included but were not limited to utilization management, quality management, health management, and cultural competency.
- An MCE questionnaire.

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

Compliance Standards Reviewed

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

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

Table 3-1—Compliance Standards

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

Data Aggregation and Analysis

Compliance Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (cited earlier in the report). The protocol describes the scoring as follows:

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

From the scores that HSAG reviewers assigned for each requirement, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value:

0.50 point), or *Not Met* (0 points), then dividing the summed weighted scores by the total number of applicable requirements for that standard.

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

Aggregating the Scores

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

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

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

4. Summary of Results

Compliance Standards

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

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

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	Internal Quality Assurance Program	21	20	20	0	0	1	100%
XII	Cultural Competency Program	17	17	17	0	0	0	100%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	8	8	8	0	0	0	100%
Total Compliance Score		**57**	**56**	**56**	**0**	**0**	**1**	**100%**

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

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

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

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

The findings from the compliance review show how well an MCO has interpreted federal regulations and the managed care contract requirements and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. **HPN** achieved full compliance in all four standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of Internal Quality Assurance Program, Cultural Competency Program, Confidentiality, and Enrollment and Disenrollment.

These findings suggest that **HPN** developed the necessary policies, procedures, and plans to operationalize all of the required elements of its contract and demonstrated compliance with the expectations of the contract. Further, interviews with **HPN** staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

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

CAP Review

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

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

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

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
I	Credentialing and Recredentialing	NA	NA	NA
II	Availability and Accessibility of Services	3	3	0
III	Subcontracts and Delegation	NA	NA	NA
IV	Provider Dispute and Complaint Resolution	NA	NA	NA
V	Provider Information	NA	NA	NA
VI	Member Rights and Responsibilities	NA	NA	NA
VII	Member Information	NA	NA	NA
VIII	Continuity and Coordination of Care	NA	NA	NA
IX	Grievances and Appeals	5	5	0
X	Coverage and Authorization of Services	NA	NA	NA
	Total	**8**	**8**	**0**

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

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

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

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

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

5. Corrective Action Plan

HPN is not required to submit to the DHCFP a CAP since all elements were scored as *Met.*

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(a)(1) *DHCFP Contract Section 3.10.6, 3.10.6.1-2, 3.10.6.4, 3.10.6.5*	1. Written IQAP Description The MCO must establish and implement an ongoing comprehensive IQAP. *a) The MCO must have a written description of its IQAP.* *b) The written description must contain a detailed set of QA objectives, which are developed annually and include a timetable for implementation and* accomplishment. *c)* The written description must provide for continuous performance of the activities, including tracking of issues over time. *d)* The written description must specify quality of care studies and other activities to be undertaken over a prescribed period of time, and methodologies and organizational arrangements to be used to accomplish them. Individuals responsible for the studies and other activities must be clearly identified and qualified to develop the studies and analyze outcomes.	**Documents Submitted:** HPN_2019 Quality Improvement Program Description a) entire document b) Pages 8-10 c) Page 27, section 9 HPN_2019 Quality Improvement Workplan, entire document **Description of Process:** In the first quarter of each year, the QIPD and the QIWP are written based off of the results of the prior year's QI Program Evaluation. The Program Description and the Workplan are the structure for the quality activities for the plan. The Workplan is a living document and may be updated during the year. The Workplan contains activities, responsible persons and committees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG strongly recommends that the MCO create an Internal Quality Assurance Program (IQAP) (description, work plan, and evaluation) specific to the Medicaid population and that is not combined with other lines of business (LOBs); for example, a commercial or marketplace LOB. Further, while the IQAP does not contain protected health information (PHI), as the MCO's IQAP is currently inclusive of multiple LOBs, data may be shared with external entities or individuals that have no		

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

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	relationship with a particular LOB(s). Additionally, HSAG recommends that the MCO review all activities and established goals in its IQAP work plan and ensure each goal is addressed in the annual evaluation, as appropriate.		
	Required Actions: None.		
42 CFR §438.330(a)(1) *DHCFP Contract Section 3.10.6.3 (A-B)*	2. Scope *a) The scope of the IQAP must be comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service. Scope must also include availability, accessibility, coordination, and continuity of care.* *b) The IQAP methodology must provide for review of the entire range of care provided by the MCO, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review. The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.(the DHCFP expects that this review occurs no less than annually.)*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description Pages 6-8 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO clearly define its CSHCN population in its IQAP description. This should align with the State's definition.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(b)(3) *DHCFP Contract Section 3.10.8.1 (D)*	3. Over- and Under-Utilization of Services The comprehensive IQAP must include mechanisms to assess both underutilization and overutilization of services, and to follow up appropriately. a) *If fraud and abuse is suspected, a referral must be made to the MCO's PIU and the DHCFP SUR Unit for appropriate action.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Evaluation Pg 47 HPN_CIR – Fraud 010 – Medicaid Potential Fraud Reporting Pg 3 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.330(b)(4) *DHCFP Contract Section 3.10.8.3 (B)*	4. Special Health Care Needs The comprehensive IQAP must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. a) *Multi-disciplinary teams are required, when appropriate, to analyze and address systems issues.*	**Documents Submitted:** HPN_QOC Investigation, IAP and Disciplinary Action **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** HSAG recommends that the MCO clearly define its special health care needs population in its IQAP. This should align with the State's definition.		
	Required Actions: None.		
42 CFR §438.330(b)(5)	5. Long-Term Services and Supports (LTSS) For MCOs providing LTSS:	**Documents Submitted:** HPN_2019 Quality Improvement Program Description Pages 6, 23-25	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	a) The IQAP must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the recipient's treatment/service plan. b) Participate in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§441.302 and 441.730(a) of this chapter) that are based, at a minimum, on the requirements on DHCFP for home and community-based waiver programs.	HPN_066 - Assessments Initial and Follow Up HPN_2019 Complex Case Management Policy pgs 1, 3, 6-8 **Description of Process:** HPN is not contracted for the LTSS population. However, we provide certain benefits that are included in the LTSS category, such as Home Health. All of our benefits are assessed across all members, and the specific category of LTSS members are not categorized separately.	
	Findings: This element was informational only and, therefore, deemed *N/A* for this review. The MCO should be prepared to have this element scored during future compliance reviews. **Recommendations:** MCO staff members confirmed a process for the reporting of adverse events via the Nevada DHCFP Serious Occurrence Report; however, the MCO also indicated that receipt of these reports is rare, suggesting that adverse events may be underreported. HSAG recommends that the MCO collaborate with the DHCFP to clarify expectations and responsibilities regarding the serious occurrence reporting process.		
	Required Actions: None.		
42 CFR §438.330(c)(2)(i-iii)	6. Performance Measurement The MCO must annually: a) Measure and report to DHCFP on its performance, using standard measures required by DHCFP.	**Documents Submitted:** HPN_WRHCO 358 HEDIS[A-2] EQRO Timeline	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	b) Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP. c) Perform a combination of the above activities.	HPN_NV2019-20_MCO_PIP-Val_Mod 1_PrenatalCare_Validation Tool_D1_121019 HPN_HEDIS Annual Report 2019 HPN_Final Medicaid Status Report HEDIS 2019 **Description of Process:** HPN collaborates with DHCFP and HSAG annually with Performance Improvement Projects and HEDIS reporting.	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.8.1	7. Quality Indicators *Quality indicators are measurable variables relating to a specified clinical or health services delivery area, which are reviewed over a period of time to monitor the process or outcomes of care delivered in that area. The MCO is required to:* *a) Identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.* *b) Monitor and evaluate quality of care through studies which include, but are not limited to, the quality indicators also specified by the CMS , with respect to the priority areas selected by DHCFP.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Evaluation pgs 9-43 **Description of Process:** The annual QI Program Evaluation tracks and trends various HEDIS measures over multiple years. HEDIS results are audited and approved by an NCQA certified vendor. Some measures had additional race and ethnicity analysis performed for Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	c) Ensure methods and frequency of data collection; ensure data accuracy; and ensure data is effective and sufficient to detect the need for program change.		
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** While many of the IQAP activities identified measurable performance goals, HSAG recommends that the MCO consider enhancing processes to set data-driven, objective, and measurable goals. For example, the work plan listed an activity as analyzing provider survey results to identify opportunities for improvement related to coordination of care between medical and behavioral healthcare. Instead, the MCO could use the results of the previous year's provider survey results to set a measurable performance goal based on areas of low satisfaction.		
	Required Actions: None.		
42 CFR §438.330(d)(1), (2)(i-iv) *DHCFP Contract Section 3.10.7.6-7*	8. Performance Improvement Projects (PIPs) The comprehensive IQAP must include PIPs, including any PIPs that focus on clinical and non-clinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and recipient satisfaction and must include the following elements: a) Measurement of performance using objective quality indicators. b) Implementation of interventions to achieve improvement in the access to and quality of care. c) Evaluation of the effectiveness of the interventions based on the performance measures. d) Planning and initiation of activities for increasing or sustaining improvement.	**Documents Submitted:** HPN_NV2019-20_MCO_PIP-Val_Mod 1_PrenatalCare_Validation Tool_D1_121019 HPN_NV2019-20_MCO_PIP-Val_Mod 2_PrenatalCare_F2_041420 **Description of Process:** PIP validation tools indicate that the health plan passed the PIP modules. While the one document from HSAG is dated outside audit period, it regards work that was performed during the audit period.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Recommendation: HSAG recommends that the MCO create a policy or add to its IQAP description the MCO's PIP methodology to be followed when conducting internal PIPs, and further incorporate PIP activities into its IQAP.		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
42 CFR §438.330(d)(3) *DHCFP Contract Section 3.10.7.5*	9. Implementation of PIPs The MCO is required to report the status and results of each project to DHCFP as requested, but not less than once per year. *a) The MCO is required to annually conduct and report on a minimum of two clinical PIPs and three non-clinical PIPs.* *b) Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, high-volume services, high-risk services, and continuity and coordination of care; non-clinical PIPs include projects focusing on availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and other complaints.*	**Documents Submitted:** HPN_PIP Reference Guide from HSAG HPN_PIP Module 1 Submission - PPC Prenatal HPN_PIP Module 1 Submission - CDC HbA1c Poor Control HPN_TA Summary_10242019 HPN_22326 PPC Prenatal Data For Sample Selection HPN_22322 HbA1c Data for Sample Selection HPN_SDOH VBC Presentation 11.25.19 pgs 4-9 HPN_ABA Presentation 8.13.19 HPN_Secret Shopper Presentation 08.2019 **Description of Process:** These are modules 1 for PIPs that are currently undergoing. We started working on them in Sep 2019 and submitted the 1st module in Nov 2019. Also included is the Rapid Cycle Reference Guide that HSAG provides us with as a guide of how to complete the PIPs. We received this in Aug of 2019. Also included is the baseline data for both PIPs, this process was started in Sep 2019 and is evidence that we were working on the PIPs in the appropriate measurement period. In addition, we participate in technical assistance calls with HSAG, notes included.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		Examples of Non-Clinical PIP information that has been shared with the State is attached. 1. ABA Improvements - Presentation 8.13.19 2. Social Determinants of Health/Value Based Contracting Improvements – Presentation 11.25.19 3. Access & Availability (Secret Shopper) Presentation August 2019	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** It is unclear to the extent that the MCO followed a scientifically sound PIP methodology in the implementation of its three non-State mandated PIPs. As such, HSAG strongly recommends that the MCO adhere to CMS EQR *Protocol 8. Implementation of Additional Performance Improvement Projects: An Optional EQR-Related Activity, October 2019* when conducting PIPs and ensure this is appropriately documented. All PIPs should be clearly identified and incorporated into the MCO's IQAP. Additionally, as the MCO is specifically required to conduct two clinical and three non-clinical PIPs annually, HSAG recommends that the MCO clearly identify in its IQAP the clinical and/or non-clinical focus of each PIP to ensure adherence to this requirement.		
	Required Actions: None.		
42 CFR §438.330(e)(2) *DHCFP Contract Section 3.10.8.7 (A-C)*	10. Program Evaluation The MCO must develop a process to evaluate the impact and effectiveness of its own IQAP. *a) The MCO must conduct regular and periodic examination of the scope and content of the IQAP to ensure that it covers all types of services in all settings.* *b) At the end of each calendar year, a written report on the IQAP must be prepared and submitted to DHCFP*	**Documents Submitted:** HPN_2019 Quality Improvement Program Evaluation (see bookmarks individual sections) **Description of Process:** There are multiple analyses included in the annual QI Program Evaluation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	which addresses quality assurance studies and other activities completed; trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and an evaluation of the overall effectiveness of the IQAP. *c) The report should include evidence that quality assurance activities have contributed to significant improvements in the care delivered to members.*		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.6.6 (A-B)	11. Provider Review *a) Review by physicians and other health professionals of the process followed in the provision of health services must be conducted.* *b) The MCO must provide feedback to health professionals and MCO staff regarding performance and patient health care outcomes.*	**Documents Submitted:** HPN_Practitioner Participation Grid HPN_Gaps In Care Report Example 08.2019 HPN_Medicaid_SMA JOC Minutes_12.4.2019 **Description of Process:** Committee and task force participation by physicians and pharmacists is listed in the document, "Practitioner Participation Grid". Other medical and behavioral health care professionals such as RN, LCSW, MSW, among others, are also active participants.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
		Gap in Care (GIC) reports are shared with provider groups that participate in the Medicaid Clinical Practice Consultant (CPC) Programs. The GIC reports are distributed by the designated CPC on a monthly basis via onsite clinic visits or by email. The reports support provider groups improve quality of care by identifying members that are currently in applicable Healthcare Effectiveness Data Information Set (HEDIS) measures. GIC reports identify members who are eligible for specific HEDIS measures and who have not received the appropriate elements of care, or have "gaps in care". The objective of identifying gaps in care is to encourage providers to conduct member outreach and thus close the gap by rendering the missing care elements.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO consider additional mechanisms to share the results of its IQAP performance with network providers (for example, summary of results of activities via provider newsletters, annual summary of performance report, IQAP evaluation publicly available on website, etc.). This could include information on how the MCO is performing in various activities as opposed to provider-specific performance. The MCO should also consider additional mechanisms to share the results of the performance of its IQAP with internal staff members (for example, IQAP evaluation on intranet or shared platform, periodic newsletters or bulletins, etc.).		
	Required Actions: None.		

Standard XI: Internal Quality Assurance Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.8.4, 3.10.8.5 (A-F)	12. Implementation of Corrective Actions *The IQAP must include written procedures for taking corrective action, as determined under the IQAP, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures must include:* *a) Specification of the types of problems requiring corrective action.* *b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems.* *c) Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff.* *d) The schedule and accountability for implementing corrective actions.* *e) The approach to modifying the corrective action if improvements do not occur.* *f) Procedures for terminating the affiliation with the physician, or other health professional or provider.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pgs 24-25 HPN_QOC Investigation, IAP and Disciplinary Action pg 6 HPN_Medicaid Provider Termination Policy **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The Quality of Care Investigation, Improvement Action Plans, and Disciplinary policy included procedures that addressed the requirements of this element with the exception of sub-element (e), which was not well defined; however, the IQAP description clarified that it would initiate improvement action plans (IAPs), monitor provider performance, and evaluate if further action is necessary such as disciplinary action including termination. While the MCO submitted a case example that confirmed proactive monitoring of provider groups and subsequent additional action, HSAG recommends that the MCO provide additional detail in its Quality of Care Investigation, Improvement Action Plans, and Disciplinary policy regarding the MCO's approach for proactively monitoring changes in practice patterns after a CAP has been completed, modifying corrective actions when		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	improvements do not occur, and assuring timely follow-up on identified issues to ensure actions for improvement have been effective.		
	Required Actions: None.		
42 CFR §438.330(b)(4) *42 CFR §438.330(d)* *DHCFP Contract Section 3.10.8.6*	13. Assessment of Effectiveness of Plans of Correction (POC) *a) As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made. In addition, changes in practice patterns must be monitored.* *b) The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pg 25 HPN_QOC Investigation, IAP and Disciplinary Action pg 7 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** The IQAP description clarified that it would initiate IAPs, monitor provider performance, and evaluate if further action is necessary such as disciplinary action including termination. While the MCO submitted a case example that confirmed proactive monitoring of provider groups and subsequent additional action, HSAG recommends that the MCO provide additional detail in its Quality of Care Investigation, Improvement Action Plans, and Disciplinary policy regarding the MCO's approach for proactively monitoring changes in practice patterns after a CAP has been completed, modifying corrective actions when improvements do not occur, and assuring timely follow-up on identified issues to ensure actions for improvement have been effective.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.1-4	14. Accountability to the Governing Body *The Governing Body of the MCO is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the MCO that is responsible for*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pg 11 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI: Internal Quality Assurance Program			
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	the MCO IQAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include: *a) There is documentation that the Governing Body has approved the overall IQAP and the annual IQAP.* *b) The Governing Body has formally designated an entity or entities within the MCO to provide oversight of the IQAP and is accountable to the Governing Body, or has formally decided to provide such oversight as a committee of the whole.* *c) The Governing Body routinely receives written reports from the IQAP describing actions taken, progress in meeting quality assurance objectives, and improvements made.*	BOD meeting on June 11 – minutes will be provided when available.	
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the IQAP description required the Board of Directors (BOD) to review and evaluate periodic reports, which was confirmed by BOD meeting minutes, HSAG recommends that the MCO formalize its process for these periodic reports in its IQAP, such as specifying a minimum reporting time frame (e.g., quarterly) and the minimum quality activities or initiatives to be included in the report.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.5 (A-D)	15. Annual IQAP Review *The Governing Body formally reviews on a periodic basis, but no less frequently than annually, a written report on the IQAP. This annual quality program evaluation report shall be submitted to the DHCFP in the second calendar quarter and at minimum must include:* *a) Studies undertaken.*	**Documents Submitted:** BOD meeting on June 11 – minutes will be provided when available. **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	b) Results. *c) Subsequent actions and aggregate data on utilization and quality of services rendered.* *d) An assessment of the IQAPs continuity, effectiveness and current acceptability.*		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.9.6	16. Program Modification *Upon receipt of regular written reports delineating actions taken and improvements made, the Governing Body must take action when appropriate, and direct that the operational IQAP be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO. This activity is documented in the minutes of the meetings of the Governing Board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pg 11 **Description of Process:** The Director of Quality Improvement submits and presents a report to the Board of Directors at their quarterly meeting.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the IQAP description required the BOD to review and evaluate periodic reports, which was confirmed by BOD meeting minutes, HSAG recommends that the MCO formalize its process for these periodic reports in its IQAP, such as specifying a minimum reporting time frame (e.g., quarterly) and the minimum quality activities or initiatives to be included in the report.		
	Required Actions: None.		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.10	17. Active QA Committee *The IQAP must delineate an identifiable structure responsible for performing quality assurance functions within the MCO. This committee or other structure must have:* *a) The structure/committee must meet on a regular basis with a specified frequency, no less than quarterly to oversee IQAP activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* *b) The role, structure and function of the structure/committee must be specified.* *c) There must be records documenting the structure and committee's activities, findings, recommendations and actions.* *d) IQAP subcommittees must be accountable to the Governing Body and must report to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.* *e) There must be active participation in the IQAP committee from MCO providers, who are representative of the composition of the MCO's providers.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pg 12-13 HPN_Practitioner Participation Grid **Description of Process:** The Quality Improvement Committee (QIC) meets at least quarterly. Various subcommittees and task forces also meet at least quarterly. Minutes are created for each of these meetings. The Director of Quality Improvement reports to the Board of Directors at their quarterly meetings. The QI Director has direct access to the Board members, if necessary. The Practitioner Participation Grid reflects current practitioner activity and does not include "guest" practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** HSAG recommends that the MCO review its QIC structure diagram included in the IQAP to ensure its accuracy and that it reflects the reporting structure of all subcommittees and task forces accountable to the IQAP. HSAG also recommends that the MCO clarify in its IQAP the frequency of when all subcommittees are required to report to the QIC. Documentation in the IQAP description suggested subcommittees and task forces report to the QIC at least annually; however, HSAG recommends that this reporting occur more frequently and that the MCO maintain documentation of the review and		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	discussion of subcommittee minutes/reports in the QIC meeting minutes. Additionally, while the MCO's documentation demonstrated the inclusion of network providers in IQAP activities, it was unclear if any network providers participated in the November 14, 2019, QIC meeting. As it is unknown if this is an isolated instance or a trend, HSAG recommends that the MCO further encourage provider participation in its QIC.		
	Required Actions: None.		
DHCFP Contract Section 3.10.11	18. IQAP Supervision *There must be a designated senior executive who is responsible for IQAP implementation. The MCO's Medical Director has involvement in quality assurance activities.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pgs 12, 17 HPN_Nov 2019 QIC Minutes HPN_CV – L.Tibaldi **Description of Process:** The Chief Medical Office has designated a senior medical director to chair the Quality Improvement Committee (QIC). The meeting is held at least quarterly and both physician leaders usually attend. The meeting chair is the medical director with oversight of the quality process and Quality Improvement Department.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.12	19. Adequate Resources *The IQAP must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pgs 17-22 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.10.13	20. Provider Participation in IQAP *a) Participating physicians and other providers must be kept informed about the written IQAP through provider newsletters and updates to the provider manual.* *b) The MCO must include in its provider contracts and employment agreements, for physician and non-physician providers, a requirement securing cooperation with the IQAP.* *c) Contracts must specify that hospitals and other vendors will allow the MCO access to the medical records of its members.*	**Documents Submitted:** HPN_Practitioner Participation Grid HPN_MEDICAID Primary Care Physician FFS Template pg. 3, 6, 8 HPN_MEDICAID Consulting Provider Template pg 6, 8 HPN_Screen Shot Quality Corner HPN_Provider Summary Guide Quality Improvement **Description of Process:** Physicians included in the Practitioner Participation Grid include community providers who regularly participate in the development of the QI Program and associated projects and analysis. In addition to those included as committee members, invited specialists in particular areas are brought in for their expertise, when needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
DHCFP Contract Section 3.10.22.1	21. Coordination of QA Activities with Other Management Activity *The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported within the MCO's organization and through the established QA channels.* *a) Quality assurance information is used in credentialing, recredentialing, and/or annual performance evaluations.* *b) Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of recipient grievances and appeals.* *c) There is a linkage between quality assurance and the other management functions of the MCO such as:* *i. Network changes.* *ii. Benefits redesign.* *iii. Medical management systems (e.g., pre-certification).* *iv. Practice feedback to practitioners.* *v. Patient education.* *vi. Recipient services.*	**Documents Submitted:** HPN_2019 Quality Improvement Program Description pgs 9 (last bullet) to 10 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendations:** While the MCO demonstrated that QOC information and results of satisfaction surveys are used in making recredentialing decisions, a documented process was not well defined. The Credentialing Committee meeting minutes demonstrated a comprehensive review of issues of both individual practitioners and organizational providers; however, the review was primarily		

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Reference	**Requirement**	**Information Submitted as Evidence by the MCO[A-1]**	**Score**
	focused on information received from external entities and not on data obtained through the MCO's IQAP. HSAG recommends that the MCO clearly identify what quality indicators are received from internal quality activities for consideration at the time of a provider's recredentialing and ensure that such quality indicators are documented in the provider's recredentialing file. While the MCO demonstrated that quality assurance information was used in credentialing as required by this element, the MCO should be prepared to demonstrate a review of data from grievances and appeals; results of quality reviews; utilization management; and member satisfactions surveys during future reviews of recredentialing files, as required under Contract 3.10.15.6(C).		
	Required Actions: None.		

Results for Standard XI: Internal Quality Assurance Program							
Total Elements	Met	=	20	X	1.00	=	20.00
	Partially Met	=	0	X	.50	=	.00
	Not Met	=	0	X	.00	=	.00
	Not Applicable	=	1	X	.00	=	.00
	Total Applicable	=	20	**Total Rate**		=	20.00
Total Rate ÷ Total Applicable				**= Total Score**			**100%**

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(1)	1. The Cultural Competency Plan (CCP) *The CCP must be updated annually and submitted to DHCFP in the second quarter of each calendar year.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01 HPN_Upload of CCP **Description of Process:** The last day of the second quarter is June 30, 2019, which was a Sunday. Therefore, the CCP was uploaded to the State on July 1, 2019.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (A)(1)	2. Contents of the CCP *The CCP must describe how care and services are delivered in a culturally competent manner.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01 **Description of Process:** Health Plan activities to ensure care and services are delivered in a culturally competent manner are included throughout the CCP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.4.2.15 (A)(2)	3. Staff Involved in the CCP *The MCO CCP must identify a staff person, title or position responsible for the CCP. If there is a change in the staff member responsible for the CCP, the MCO notifies the DHCFP.*	**Documents Submitted:** HPN_Responsibility of CCP Notification **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (A)(3)	4. Staff Recruitment and Retention *The CCP must contain a description of staff recruitment and retention. The MCO must demonstrate how it plans to recruit and retain staff who can meet the cultural needs of the MCO's members. Cultural competence is part of job descriptions.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 9-11 HPN_Case Manager Job Description pg 2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (B)(1)	5. Training Program *The training program:* *a) Consists of the methods the MCO uses to ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery to members of all cultures;*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 9-11 HPN_CC Training Report **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) Is regularly assessed to determine the training needs of the staff, and the MCO updates the training programs; and *c) Is customized based on the nature of the contracts the MCO has with providers and/or members.*		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (B)(2)	6. Education Program *The education program:* *a) Consists of methods the MCO uses for providers and other subcontractors with direct member contact;* *b) Is designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 8-9 HPN_Provider Cultural Training Screenshot **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (B)(2)	7. Training Providers and Subcontractors *The MCO must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 8-9 HPN_SiteVisitForm pg 2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	8. Culturally Competent Services and Translation/Interpretation Services *The MCO describes the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the MCO's members.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01 pg 2-3, 9 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	9. Regular Assessment of Needs *A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the MCO's membership.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 6 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(1)	10. Evaluating the Network *Culturally competent care requires that the MCO regularly evaluate its network, outreach services, and other programs to improve accessibility and quality of care for its membership. It also must describe the*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 3-8 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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	provision and coordination needed for linguistic and disability-related services.		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.10(d)(5)(i) *DHCFP Contract Section 3.4.2.15 (C)(2)*	11. Translation Services *The MCO must make members aware that translation services are available and will be provided by someone who is proficient and skilled in translation language(s). The availability and accessibility of translation services is not predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for translation purposes, but members must not be encouraged to substitute a friend or relative for translation services.* *(Note: Verification of 15 languages as required by Section 1557 of ACA)*	**Documents Submitted:** HPN_Member Handbook pg 2-4, 6, 15-16, 20, 58, 67 (Highlighted) HPN_1557 Taglines Link on Website **Description of Process:** The MyHPNMedicaid website is available in both English and Spanish (identified as the prevalent alternate language in Nevada). In addition, all critical documents and most non-critical member communications are offered in both English and Spanish. The 1557 Notices are posted on our website and are included in our Member Handbook (pgs 3-4), per direction from the DHCFP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.10(h)(1)(vii)	12. Providers' Cultural and Linguistic Capabilities *The MCO must make members aware of the provider's cultural and linguistic capabilities, including languages (including American Sign*	**Documents Submitted:** HPN_Provider Directory Screenshot **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(3)	13. Quality Review of Translated Material *The MCO must demonstrate that it uses a quality review mechanism to ensure that translated materials convey intended meaning in a culturally appropriate manner.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 12 HPN_Translation Certificate Example **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438/10(d)(1-2) *DHCFP Contract Section 3.4.2.15 (C)(3)(a)*	14. Ten Percent Threshold for Providing Written Translation *All materials shall be translated when the MCO is aware that a language is spoken by 3,000 or 10 percent (whichever is less) of the MCO's members who also have Limited English proficiency (LEP) in that language.*	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01pg 14 HPN_WRHCO 346 Member and Provider Communications Policy **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438/10(d)(1-3) *DHCFP Contract Section 3.4.2.15 (C)(3)(b)*	15. Five Percent Threshold for Providing Written Translation *All vital materials shall be translated when the MCO is aware that a language is spoken by 1,000 or 5% (whichever is less) of the MCO's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, appeal and grievance notices, provider directories, and vital information from the member handbook.*	**Documents Submitted:** HPN_WRHCO 346 Member and Provider Communications Policy **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (C)(3)(c)	16. Written Notices Informing Members of Interpretation and Translation Services • *All written notices informing members of their right to interpretation and translation services shall be translated into the appropriate language when the MCO's caseload consists of 1,000 members that speak that language and have LEP.*	**Documents Submitted:** HPN_WRHCO 346 Member and Provider Communications Policy **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.4.2.15 (D)(1)	17. Evaluation and Assessment of CCP	**Documents Submitted:** HPN_Summary Report of Cultural Competency Plan_2019.07.01	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XII: Cultural Competency Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	a) The MCO must evaluate the CCP to determine its effectiveness and identify opportunities for improvement. *b) A summary report of the evaluation must be sent to DHCFP.* *c) The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or MCO employee surveys. If issues are identified, they must be tracked and trended, and actions must be taken to resolve the issue(s).*	HPN_Upload of CCP **Description of Process:** Evaluations of the effectiveness of the CCP and opportunities for improvement are included throughout the document, which was provided to the DHCFP on 07.01.2019	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Results for Standard XII: Cultural Competency Program						
Total Elements	Met	= 17	X	1.00	=	17.00
	Partially Met	= 0	X	.50	=	.00
	Not Met	= 0	X	.00	=	.00
	Not Applicable	= 0	X	.00	=	.00
	Total Applicable	= 17	**Total Rate**		=	17.00
Total Rate ÷ Total Applicable			**= Total Score**			**100%**

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.224 *45 CFR parts 160 and subparts A and E of 164* *DHCFP Contract Section 3.10.16.9*	1. Confidentiality of Member Information The MCO uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and subparts A and E of 164, to the extent that these requirements are applicable. *a) The MCO acts to ensure that the confidentiality of specified member information and records is protected.* *b) The MCO must establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records.*	**Documents Submitted:** HPN_Privacy Policy Manual (Entire Document) HPN_2019 HIPAA Privacy Policy pg 1-2 HPN_Site Visit Policy_ pg 2 HPN_Provider Site Visit Tool pg 2 HPN_PSG Section 8 Medicaid, 8.12 Medical Records pg 12 HPN_MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 6 HPN_MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 7 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (B)*	2. Office Sites Maintaining Confidentiality of Member Information *The MCO must ensure that member care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.*	**Documents Submitted:** HPN_Site Visit Policy pg 2 HPN_Provider Site Visit Tool pg 2 HPN_PSG Section 8 Medicaid, 8.12 Medical Records pg 12 HPN_MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 6 HPN_MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 7 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (C)(1-3)*	3. Releasing Confidentiality of Member Information *The MCO holds confidential all information obtained by its personnel about members related to their examination, care and treatment, and does not divulge it without the member's authorization, unless:* *a) It is required by law, or pursuant to a hearing request on the member's behalf;*	**Documents Submitted:** HPN_Privacy Policy Manual Section 2 pgs 11-14 HPN_2019 HIPAA Privacy Policy pg 1-2 PN_PSG Section 8 Medicaid, 8.12 Medical Records pg 12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) It is necessary to coordinate the member's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or *c) It is necessary in compelling circumstances to protect the health or safety or an individual.*	HPN_MEDICAID Consulting Provider Template Article III H Records and Reports 4 pg 6 HPN_MEDICAID Primary Care Physician FFS Template Article III J Records and Reports 4 pg 7 **Description of Process:**	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *45 CFR §164.410*	4. Reporting Inappropriate Use and Disclosure of Protected Health Information (PHI) to DHCFP The MCO promptly reports to DHCFP any inappropriate use or disclosure of PHI, including a breach of unsecured PHI as required by 45 CFR §164.410 and any security incident the MCO has knowledge of or reasonably should have knowledge of under the circumstances.	**Documents Submitted:** HPN_Incident Reporting and Handling Policy pg 1, 3 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 *DHCFP Contract Section 3.10.16.9 (E)*	5. Requirements for Confidentiality of Patient Information *The MCO may disclose member records whether or not authorized by the member, to qualified personnel, defined as persons or agency representatives who are*	**Documents Submitted:** HPN_2019 HIPAA Privacy Policy pg 1-2 HPN_Privacy Policy Manual Section 2 pgs 11-14	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	subject to standards of confidentiality that are comparable to those of the State agency.	**Description of Process:**	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(a)	6. Discovery of a Breach The MCO, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCO to have been accessed, acquired, used, or disclosed as a result of such breach.	**Documents Submitted:** HPN_Incident Reporting and Handling Policy pg 3 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(b)	7. Timeliness of Notification Except as provided in §164.412 (law enforcement delay), the MCO provides notification to the individuals affected by a breach without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach.	**Documents Submitted:** HPN_Incident Reporting and Handling Policy pg 3 HPN_UHG Guidance for HHS Federal Breach Media and Substitute Notice Requirements pg 5 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

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

Standard XIII: Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
45 CFR §164.404(d)(1)(i-ii)	9. Method of Notification The notification shall be provided in the following form: a) Written notification by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. The notification may be provided in one or more mailings as information is available. b) If the MCO knows the individual is deceased and has the address of the next of kin or personal representative of the individual (as specified under §164.502(g)(4) of subpart E), written notification by first-class mail to either the next of kin or personal representative of the individual. The notification may be provided in one or more mailings as information is available.	**Documents Submitted:** HPN_UHG Guidance for HHS Federal Breach Media and Substitute Notice Requirements pg 2-3 HPN_Member Notification Letter Template **Description of Process:** The Corporate Legal and Privacy Department regularly monitor state, federal, and international laws concerning the requirements for disclosures that must be included in individual breach notifications. The result of this activity is the maintenance of breach notification templates designed for specific types of breaches and/or a specific fact pattern. (copy of template has been provided)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
45 CFR §164.404(d)(2)	10. Substitute Notice In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual shall be provided. a) Substitute notice need not be provided in the case in which there is insufficient or out-of-date	**Documents Submitted:** HPN_UHG Guidance for HHS Federal Breach Media and Substitute Notice Requirements pg 2-3 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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

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

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

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.5.1	1. Eligibility and Enrollment Functions *The MCO shall establish and implement enrollment procedures and maintain applicable enrolled member data.*	Documents Submitted: HPN_WRHCO 284 Enrollment_Reenrollment_Disenrollment HPN_Medicaid Enrollment SOP Description of Process:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.5.5, 3.5.7.8	2. Change in Status *The MCO must notify a member that any change in status, including family size and residence, must be immediately reported by the member to their DWSS eligibility worker.* *a) Within seven (7) calendar days of becoming aware of any changes in a member's status, including changes in family size and residence, the MCO must electronically report the change(s) to the DHCFP via the provider supplied data file.* *b) The MCO must provide DHCFP with notification of all births and deaths and demographic changes.*	Documents Submitted: HPN_Member Handbook pg 57 HPN_Address Change Requests pg 7 HPN_Medicaid.Changes_TechSpec Description of Process:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Findings: HSAG has determined that the MCO has met the requirements for this element. Additionally, HSAG determined that sub-elements (a) and (b) are no longer applicable.		
	Required Actions: None.		
42 CFR §438.56(d)(1)(ii) *DHCFP Contract Section 3.5.7.3 (F)(1)(a-d)*	3. Member Request for Disenrollment The member must submit an oral or written request to the MCO to process disenrollment requests. *a) Any member may request to switch MCO's for good cause (as defined in 42 CFR 438.56(d)(2)) at any time.* *b) These members must contact their current MCO orally or in writing for permission to disenroll.*	**Documents Submitted:** HPN_Member Handbook pg 69 HPN_WRHCO 284 Enrollment_Reenrollment_Disenrollment pg 1-2 HPN_Medicaid Disenrollment SOP pg 3-4 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(e)(1-2) *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (G)*	4. Sufficient Cause to Disenroll *If the MCO determines that there is sufficient cause to disenroll, they will notify the DHCFP by using the form supplied.* *a) The MCO must make a determination as expeditiously as the member's health requires and within a timeline that may not exceed fourteen (14) calendar days following receipt of the request for disenrollment.*	**Documents Submitted:** HPN_WRHCO 284 Enrollment_Reenrollment_Disenrollment pg 2 HPN_Medicaid Disenrollment SOP pg 3 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.56(c)(1) *42 CFR §438.56(d)(2)(i-v)* *42 CFR §438.56(d)(3)(i)* *42 CFR §438.702(a)(3)* *DHCFP Contract Section 3.5.7.3 (H)*	5. MCO Denies Request to Disenroll *If the MCO denies the request for disenrollment for lack of good cause the MCO must send a Notice of Decision in writing to the member upon the date of the decision.* *a) Appeal rights must be included with the Notice of Decision.* *b) The MCO is required to inform the member of their right to first appeal through the MCO and if the appeal is denied to request a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained to the member and provided by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(5); 42 CFR §438.414; and 42 CFR §438.10(g)(1).*	**Documents Submitted:** HPN_WRHCO 284 Enrollment_Reenrollment_Disenrollment pg 3 HPN_Medicaid Disenrollment SOP pg 3 HPN_Disenrollment Denial Letter Template HPN_Appeal Denial Letter w SFH Rights Example **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element. **Recommendation:** The MCO's Notice of Decision letter included appeal and State fair hearing rights; however, the letter also contained language regarding continuation of benefits, which would not be applicable for disenrollment decisions. HSAG recommends the MCO review the language in the Notice of Decision letter to determine if the continuation of benefits language should be removed.		
	Required Actions: None.		
42 CFR §438.56(d)(5)(i-ii) *42 CFR §438.56(e)(1)* *DHCFP Contract Section 3.5.7.3 (I)*	6. Use of the MCO's Grievance System *DHCFP requires that the member seek redress through the MCO's grievance system before making a determination on the member's request.*	**Documents Submitted:** HPN_WRHCO 284 Enrollment_Reenrollment_Disenrollment pg 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	a) The grievance process must be completed in time to permit the disenrollment (if approved) to be effective no later than the first day of the second month following the month in which the member files the request.	**Description of Process:**	
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (A)*	7. Disenrollment at the Request of the MCO *The MCO may request disenrollment of a member if the continued enrollment of the member seriously impairs the MCO's ability to furnish service to either the particular member or other members.* *a) The MCO must confirm that the member has been referred to the MCO's Member Services Department and has either refused to comply with this referral or refused to act in good faith to attempt to resolve the problem.*	**Documents Submitted:** HPN_WRHCO 351 Disenrollment at the Request of HPN pg 2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(b)(2) *DHCFP Contract Section 3.5.7.4 (C)(1-7)*	8. Reasons an MCO May Not Request Disenrollment The MCO may not request disenrollment of a member for any of the following reasons: a) An adverse change in the member's health status;	**Documents Submitted:** HPN_WRHCO 351 Disenrollment at the Request of HPN pg 1-2 **Description of Process:**	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XIV: Enrollment and Disenrollment			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	b) A pre-existing medical condition; c) The member's utilization of medical services; d) Diminished mental capacity; e) Uncooperative or disruptive behavior resulting from his or her special needs (except when continued enrollment of such a member seriously impairs the MCO's ability to furnish services to either this particular member or other members); f) A member's attempt to exercise his or her grievance or appeal rights; or g) Based on the member's national origin creed, color, sex, religion, or age.		
	Findings: HSAG has determined that the MCO has met the requirements for this element.		
	Required Actions: None.		

Results for Standard XIV: Enrollment and Disenrollment							
Total Elements	Met	=	8	X	1.00	=	8.00
	Partially Met	=	0	X	.50	=	.00
	Not Met	=	0	X	.00	=	.00
	Not Applicable	=	0	X	.00	=	.00
	Total Applicable	=	8	**Total Rate**		=	8.00
Total Rate ÷ Total Applicable				**= Total Score**			**100%**

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

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

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
DHCFP Contract Section 3.7.5.7 (B)	16. PCP Appointments PCP appointments are available as follows: a) Medically necessary, primary care provider appointments are available within two (2) calendar days; b) Same day, urgent care PCP appointments; and c) Routine care PCP appointments are available within two weeks. The two-week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every two weeks.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs. 17-18 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) **Description of Process:** N/A	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and		

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

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff members stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that appointment availability standards for PCP appointments are consistent with the MCO contract. HPN must ensure that the appointment availability standards for PCP appointments communicated to providers and members are consistent with the degree of urgency described in the MCO contract.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	HPN has revised the attached Provider Summary Guide, Section 8 (page 3), Access and Availability Policy (page 1-2) and Member Handbook (page 23) to be consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. Shawna DeRousse, Sarah Fox, Devan Ramirez and Kim Johnson worked to align the documents and bring the element into compliance. Per the requirements of the contract for approval of changes to the Provider Summary Guide and Member Handbook, these documents will also be sent through the normal approval process prior to publication and posting on our website. Further, the provider advocates and member services representatives will educate providers and members, respectively, on the timeliness standards and expectations. This education will begin immediately upon approval of the CAP.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
DHCFP Response (To be completed by DHCFP/HSAG.)	The revised Provider Summary Guide included the appointment availability standards for PCP appointments, which were consistent with the MCO contract. The revised Member Handbook included appointment availability standards for PCP appointments, which were consistent with the MCO contract. The revised Access and Availability policy included the definition and timeframes consistent with the contract requirements for PCP office visits; however, the reference to the service type was confusing. Emergent care was defined as, "medically necessary primary physician appointments for Medicaid" within 2 calendar days. Urgent care, however, was defined as, "acute but not life or limb-threatening" within the same day. The previous policy included the following appointment standards: urgent care (within 24 hours) and emergent care (same day), which indicated that emergent care was a more intense level of care. The revised policy indicated that emergent care for PCP visits was a less intense level of care since a member could be seen within 2 calendar days. The term, "emergent care," used in other parts of the same policy was defined as a more intense level of care with more stringent appointment standards. While the revisions to the Provider Summary Guide and the Member Handbook clarified the PCP appointment availability standards to be consistent with the contract, it is unclear from the revised policy if staff members would be able to discern the appropriate appointment availability standards for PCP visits due to the confusing descriptions of emergent and urgent care. **DHCFP Comment:** The revisions to the Member Handbook and Provider Summary Guide are approved. Regarding the policy, HPN should clarify the distinction between urgent and emergent care and ensure that the appropriate nomenclature and appointment availability standards are included. Further, HPN must provide to DHCFP the date by which all actions described in the CAP, including provider and member education, will be completed.		
Corrective Action Plan, Second Submission	HPN has revised the Access and Availability policy (attached, page 1) to ensure that staff are able to discern the appropriate availability standard for PCPs. The PCP visit standards now clearly differentiate between routine-care PCP appointments (within 14 days), non-routine PCP appointments (within 2 days), and urgent PCP appointments (same day). Emergent care, as a service level for Specialists, remains a same day standard. HPN has completed (07/16/18) a fax-blast (attached) to all Medicaid PCP providers with the revised Access Standards. The Provider Summary Guide has been updated on HPN's website. A flyer (attached) is included with the site visit packets. General education to Providers on Access Standards will not have a finite end-date, as it is an ongoing effort, with reminders		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	provided during site visits and verbal conversations with provider advocates, as well as semi-annual newsletters and other educational events. HPN has posted the approved changes to the Member Handbook to the HPN Medicaid website. The Member Services team will provide education to members during calls as appropriate. General education to members on Access Standards will not have a finite end-date, as it is an ongoing effort.		
DHCFP Response (To be completed by DHCFP/HSAG.)	HPN submitted a revised Access and Availability policy that differentiates between urgent and emergent care and includes appropriate appointment availability standards. HPN also submitted a copy of the fax blast sent to all Medicaid PCP providers of the revised access standards. HPN noted that on-going general education to Providers on access standards takes place through site visits, verbal conversations with provider advocates, semi-annual newsletters, and other educational events. HPN submitted a CAP and supporting documentation that address the remaining deficiencies. **DHCFP Comment:** The revised CAP is approved.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: • HPN_2019 PSG Section 8 - pg. 13-14 – Updated and approved by DHCFP in January, 2019, the Provider Summary Guide section on appointment standards remain since the CAP was originally approved. • HPN_Member Handbook pg 23 – the Access standards are included for members, at a reduced reading level, and match the provider expectations in the Provider Summary Guide. • HPN_100-03 Site Visit Policy – It is a requirement of the site visit to educate providers on the access and availability standards. • HPN_Provider Availability Standards Flyer – this flyer is shared with all providers. • HPN_A and A Policy 10.2019			
Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element.			
Required Actions: None.			☒ Met ☐ Not Met

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.7.5.8 (B)	20. Monitoring Appointment Standards Concerning the education of its provider network regarding appointment time requirements the MCO shall: a) Monitor the adequacy of its appointment process and compliance; and b) Implement a POC when appointment standards are not met.	**Documents Submitted:** II_HPN_100-3 Site Visit Policy II_HPN_Access Avail Policy 2017 pgs. 15-16, 18-19, 21-23 II_HPN Provider Summary Guide Sec 8.6 pg. 3 (pages 68-69) II_HPN_100-43 Provider Corrective Actions Policy **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2017 HPN Provider Summary Guide included the provision that performance against the standards would be measured continually by the Provider Services Department. The HPN 100-3 Site Visit Policy detailed the process for conducting site visits at provider offices to verify compliance with appointment standards. The HPN 100-43 Provider Corrective Actions Policy described the process and procedures for monitoring providers and initiating and requiring corrective action if the provider fails to comply with HPN's contractual and policy requirements related to appointment standards. The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		
	Recommendations: HPN must ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	HPN has revised the attached Provider Summary Guide, Section 8 (page 3), Access and Availability Policy (page 1-2) and Member Handbook (page 23) to be consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. Shawna DeRousse, Sarah Fox, Devan Ramirez and Kim Johnson worked to align the documents and bring the element into compliance. Per the requirements of the contract for approval of changes to the Provider Summary Guide and Member Handbook, these documents will also be sent through the normal approval process prior to publication and posting on our website. Further, the provider advocates and member services representatives will educate providers and members, respectively, on the timeliness standards and expectations. This education will begin immediately upon approval of the CAP.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The revised Provider Summary Guide included the appointment availability standards for PCP appointments, which were consistent with the MCO contract. The revised Member Handbook included appointment availability standards for PCP appointments, which were consistent with the MCO contract. The revised Access and Availability policy included the		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	definition and timeframes consistent with the contract requirements for PCP office visits; however, the reference to the service type was confusing. Emergent care was defined as, "medically necessary primary physician appointments for Medicaid" within 2 calendar days. Urgent care, however, was defined as, "acute but not life or limb-threatening" within the same day. The previous policy included the following appointment standards: urgent care (within 24 hours) and emergent care (same day), which indicated that emergent care was a more intense level of care. The revised policy indicated that emergent care for PCP visits was a less intense level of care since a member could be seen within 2 calendar days. The term, "emergent care," used in other parts of the same policy was defined as a more intense level of care with more stringent appointment standards. While the revisions to the Provider Summary Guide and the Member Handbook clarified the PCP appointment availability standards to be consistent with the contract, it is unclear from the revised policy if staff members would be able to discern the appropriate appointment availability standards for PCP visits due to the confusing descriptions of emergent and urgent care. **DHCFP Comment:** The revisions to the Member Handbook and Provider Summary Guide are approved. Regarding the policy, HPN should clarify the distinction between urgent and emergent care and ensure that the appropriate nomenclature and appointment availability standards are included. Further, HPN must provide to DHCFP the date by which all actions described in the CAP, including provider and member education, will be completed.		
Corrective Action Plan, Second Submission	HPN has revised the Access and Availability policy (attached, page 1) to ensure that staff are able to discern the appropriate availability standard for PCPs. The PCP visit standards now clearly differentiate between routine-care PCP appointments (within 14 days), non-routine PCP appointments (within 2 days), and urgent PCP appointments (same day). Emergent care, as a service level for Specialists, remains a same day standard. HPN has completed (07/16/18) a fax-blast (attached) to all Medicaid PCP providers with the revised Access Standards. The Provider Summary Guide has been updated on HPN's website. A flyer (attached) is included with the site visit packets. General education to Providers on Access Standards will not have a finite end-date, as it is an ongoing effort, with reminders provided during site visits and verbal conversations with provider advocates, as well as semi-annual newsletters and other educational events.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	HPN has posted the approved changes to the Member Handbook to the HPN Medicaid website. The Member Services team will provide education to members during calls as appropriate. General education to members on Access Standards will not have a finite end-date, as it is an ongoing effort.		
DHCFP Response (To be completed by DHCFP/HSAG.)	HPN submitted a revised Access and Availability policy that differentiates between urgent and emergent care and includes appropriate appointment availability standards. HPN also submitted a copy of the fax blast sent to all Medicaid PCP providers of the revised access standards. HPN noted that on-going general education to Providers on access standards takes place through site visits, verbal conversations with provider advocates, semi-annual newsletters, and other educational events. HPN submitted a CAP and supporting documentation that address the remaining deficiencies. **DHCFP Comment:** The revised CAP is approved.		

2020 CAP Compliance Review

MCO Evidence of Compliance:

- HPN_2019 PSG Section 8 - pg. 13-14 – Updated and approved by DHCFP in January/2019, the Provider Summary Guide section on appointment standards remain since the CAP was originally approved.
- HPN_Member Handbook pg 23 – the Access standards are included for members, at a reduced reading level, and match the provider expectations in the Provider Summary Guide.
- HPN_100-03 Site Visit Policy – It is a requirement of the site visit to educate providers on the access and availability standards.
- HPN_Provider Availability Standards Flyer – this flyer is shared with all providers.
- HPN_A and A Policy 10.2019

HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element.

Required Actions: None.

☒ Met
☐ Not Met

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.10.17	26. Standards for Availability and Accessibility The MCO must: a) Establish standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice and recipient service lines) and complies with this RFP. b) Assess performance on these dimensions of access against the established standards.	**Documents Submitted:** II_HPN_Access Avail Policy 2017 pgs. 17-19, 25 II_HPN Provider Summary Guide Sec 5.10 pg 10 (Page 34) **Description of Process:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The 2017 HPN Provider Summary Guide, HPN Access and Availability Policy, and the member handbook all contained PCP appointment availability standards; however, the documents differed with respect to the PCP appointment standards, and none of the documents were consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. The 2017 HPN Provider Summary Guide included appointment availability standards for emergent care (same day), urgent care (within two calendar days), and routine PCP appointments (within two weeks). The HPN Access and Availability Policy 2017 included appointment availability standards for preventive care (within 30 calendar days), routine care (within 14 calendar days), urgent care (within 24 hours), and emergent care (same day). The HPN Member Handbook contained PCP appointment standards for emergent care (immediately), urgent care (within 24 hours), routine care (within seven days), and preventive well-child visits (within one month). Although HPN staff members described the process for conducting site visits to monitor providers on appointment availability standards, staff members confirmed that provider services advocates monitored to the standards described in the Provider Services Manual, which did not meet the standards defined for PCP appointments. Further, HPN staff members confirmed that they monitored providers to standards that differed from those communicated to members via the member handbook. HPN staff members confirmed that the descriptions of the standards were inconsistent across the three documents and were also inconsistent with the degree of urgency outlined in the MCO contract for PCP appointments. HPN staff members stated that they would revise the documents to be consistent with the MCO contract nomenclature and definitions described in this element.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: HPN must ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract. Further, HPN must assess its performance against contractually required standards.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	HPN has revised the attached Provider Summary Guide, Section 8 (page 3), Access and Availability Policy (page 1-2) and Member Handbook (page 23) to be consistent with the MCO contract language and nomenclature outlined in this element for medically necessary primary care appointments, same-day urgent PCP appointments, and routine care PCP appointments. Shawna DeRousse, Sarah Fox, Devan Ramirez and Kim Johnson worked to align the documents and bring the element into compliance. Per the requirements of the contract for approval of changes to the Provider Summary Guide and Member Handbook, these documents will also be sent through the normal approval process prior to publication and posting on our website. Further, the provider advocates and member services representatives will educate providers and members, respectively, on the timeliness standards and expectations. This education will begin immediately upon approval of the CAP.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The revised Provider Summary Guide included the appointment availability standards for PCP appointments, which were consistent with the MCO contract. The revised Member Handbook included appointment availability standards for PCP appointments, which were consistent with the MCO contract. The revised Access and Availability policy included the definition and timeframes consistent with the contract requirements for PCP office visits; however, the reference to the service type was confusing. Emergent care was defined as, "medically necessary primary physician appointments for Medicaid" within 2 calendar days. Urgent care, however, was defined as, "acute but not life or limb-threatening" within the same day. The previous policy included the following appointment standards: urgent care (within 24 hours) and emergent care (same day), which indicated that emergent care was a more intense level of care. The revised policy indicated that emergent care for PCP visits was a less intense level of care since a member could be seen within 2 calendar days where as for urgent care, a member would be seen on the same day. The term, "emergent care," used in other parts of the same policy was defined as a more intense level of care with more stringent appointment standards. While the revisions to the Provider Summary Guide and the Member Handbook clarified the PCP appointment availability standards to be consistent with the		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	contract, it is unclear from the revised policy if staff members would be able to discern the appropriate appointment availability standards for PCP visits due to the confusing descriptions of emergent and urgent care. **DHCFP Comment:** The revisions to the Member Handbook and Provider Summary Guide are approved. Regarding the policy, HPN should clarify the distinction between urgent and emergent care and ensure that the appropriate nomenclature and appointment availability standards are included. Further, HPN must provide to DHCFP the date by which all actions described in the CAP, including provider and member education, will be completed.		
Corrective Action Plan, Second Submission	HPN has revised the Access and Availability policy (attached, page 1) to ensure that staff are able to discern the appropriate availability standard for PCPs. The PCP visit standards now clearly differentiate between routine-care PCP appointments (within 14 days), non-routine PCP appointments (within 2 days), and urgent PCP appointments (same day). Emergent care, as a service level for Specialists, remains a same day standard. HPN has completed (07/16/18) a fax-blast (attached) to all Medicaid PCP providers with the revised Access Standards. The Provider Summary Guide has been updated on HPN's website. A flyer (attached) is included with the site visit packets. General education to Providers on Access Standards will not have a finite end-date, as it is an ongoing effort, with reminders provided during site visits and verbal conversations with provider advocates, as well as semi-annual newsletters and other educational events. HPN has posted the approved changes to the Member Handbook to the HPN Medicaid website. The Member Services team will provide education to members during calls as appropriate. General education to members on Access Standards will not have a finite end-date, as it is an ongoing effort.		
DHCFP Response (To be completed by DHCFP/HSAG.)	HPN submitted a revised Access and Availability policy that differentiates between urgent and emergent care and includes appropriate appointment availability standards. HPN also submitted a copy of the fax blast sent to all Medicaid PCP providers of the revised access standards. HPN noted that on-going general education to Providers on access standards takes place through site visits, verbal conversations with provider advocates, semi-annual newsletters, and other educational events. HPN submitted a CAP and supporting documentation that address the remaining deficiencies.		

Standard II: Availability and Accessibility of Services			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	DHCFP Comment: The revised CAP is approved.		

2020 CAP Compliance Review

MCO Evidence of Compliance:

- HPN_2019 PSG Section 8 - pg. 13-14 – Updated and approved by DHCFP in January/2019, the Provider Summary Guide section on appointment standards remain since the CAP was originally approved.
- HPN_Member Handbook pg 23 – the Access standards are included for members, at a reduced reading level, and match the provider expectations in the Provider Summary Guide.
- HPN_100-03 Site Visit Policy – It is a requirement of the site visit to educate providers on the access and availability standards.
- HPN_Provider Availability Standards Flyer – this flyer is shared with all providers.
- HPN_A and A Policy 10.2019

HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element.

Required Actions: None.	☒ Met ☐ Not Met

SFY 2018–19 CAP Compliance Review

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
DHCFP Contract Section 3.5.7.3(H)	1. Denying Recipient Requests for Disenrollment If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a Notice of Decision in writing to the recipient upon the date of decision. Appeal rights must be included with the Notice of Decision.	**Documents Submitted:** IX_HPN_Disenrollment SOP pgs 3-5 IX_HPN_WRHCO 284 Disenrollment at Member's Request **Description of Process:**	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The document, Disenrollment SOP [Standard Operating Procedure], included the provision that if a request for disenrollment was denied due to lack of good cause, the MCO would generate a denial letter. The policy, WRHCO 284 Disenrollment at Member's Request, described HPN's policy for providing a notice of decision and the member's appeal rights to the member within 10 calendar days of the decision if the MCO denies the member's request for disenrollment. During the on-site interview, HPN staff members confirmed that they sent the notice within 10 days of the decision and confirmed that this practice was not in compliance with the requirement to send the notice of decision on the date of the decision.		
	Recommendations: If the MCO denies the request for disenrollment for lack of good cause, the MCO must send a notice of decision in writing to the member on the date of decision.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	The documents referenced above, *Member Disenrollment SOP* and *WRHCO 284* have been revised (attached) by their respective owners to indicate that in the event of a request for disenrollment, the member will be sent a written notice ***on the date*** of the decision. The documents have been approved by the Policy Committee and employees have been trained regarding the process. This change is complete as of August 9, 2019.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Medicaid Disenrollment Standard Operating Procedure (SOP), revised on July 22, 2019 and the policy, Disenrollment at the Request of the Member, revised in July 2019, described the provision that if the MCO denies the request for disenrollment for lack of good cause, the MCO must send a notice of decision in writing to the member on the date of decision. HPN staff members confirmed that staff members received training regarding the revised policies.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: As it has been less than year since the CAP – the updated documentation provided for the CAP is still the most current. • HPN_WRHCO 284 Disenrollment at the Request of Member pg 2 • HPN_Medicaid Disenrollment SOP pg 3 However, in addition, we have created a log for disenrollment requests, that tracks the date of the decision and the date the member is mailed the notice. • HPN_Medicaid Disenrollment Request Log 2020			
HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element. **Recommendation:** HSAG recommends that the MCO add the decision date to the decision letter template for member requests for disenrollment.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.210(d)(1)(i-ii) *42 CFR §438.404(c)(4)(i-ii)* *42 CFR §438.408(c)(1)(i-ii)* *DHCFP Contract Section 3.13.3.1*	14. Standard Authorization Decisions The MCO must provide standard authorization decisions as expeditiously as the recipient's health requires and within the State's established timelines that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the recipient or provider requests the extension; or, the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's interests. The MCO must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.	**Documents Submitted:** IX_HPN_UCSMM.06.16 Initial Review Timeframes pg 5 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, UCSMM.06.16 Initial Review Timeframes, contained the time frames and provisions for providing standard authorization decisions within 14 calendar days following the request. The policy did not contain provisions for extending the time frame for a standard authorization decision by 14 calendar days, only for retrospective reviews. HPN staff members confirmed that the language was part of the appeals policy but was not included in the policies that supported standard authorization decisions. After the on-site visit, HPN staff members provided a letter template that could be sent to members when there is a need to request additional information. The letter template contained language to inform the member that the MCO was extending the decision-making time frame and that the MCO requested information from the member's provider to make a decision regarding the service authorization. The letter also informed the member to file a grievance if the member disagrees with the MCO's plan to collect additional information. The letter template, however, did not specify whether the letter was used for standard authorization decisions or expedited authorization decisions. There was no accompanying policy, procedure, or SOP that described the process for issuing the letter; therefore, it was not clear how staff members were instructed when to issue the letter because it was not clear at the time of the on-site interview that staff members were aware that this letter existed.		
	Recommendations: If the MCO requires an extension of up to 14 additional calendar days to make a standard authorization decision if the member or provider requests the extension, or the MCO justifies (to the DHCFP upon request) a need for additional		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	information and how the extension is in the member's interests, the MCO must provide written notice of the reason for the extension and inform the member of the right to file a grievance.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	As mentioned during the on-site, Shawna DeRousse and Serena Siegfried are in the process of updating the health plan's former UM policy – HCO100, which will replace the current UCSMM policies. The HCO 100 policy includes the details regarding requesting the 14 day extension for both standard and expedited authorizations, including the requirements for the written notice to the member. The entire policy is quite lengthy, and is expected to be updated and ready for use by 9/1/19. However, the section of the policy relating to this recommendation (100.05) has been updated, approved, and communicated to staff for use as of August 9, 2019. (See section 3.5) In addition, the Medical Management department SOPs ADT -01 and MCD-01 (attached) have been updated to reflect the process for requesting extensions for both standard and expedited authorization requests, as well as the requirements for the written response to the member. Shelean Sweet, Director Preservice Review, has communicated these SOP updates to her department as of August 9, 2019.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Elective Adverse Determination Process (Denial), revised on July 29, 2019, and the policy, Review Process for NV Medicaid, revised July 29, 2019 contained the provision that if the MCO needs to extend the timeframe by 14 days to make a routine authorization decision, the MCO sends a notice to the member to inform the member about their right to file a grievance if they disagree with the extension. The policy, Timeliness of UM Decisions-HCO 100.05, revised August 2019 also contained the provision that the MCO provides notice to the member if the MCO requires an extension to make a decision and informs the member of their right to file a grievance if the member disagrees with the extension. HPN staff members confirmed that this section (100.05) of the larger policy has been approved for use as of August 9, 2019 and staff members are aware of the policy. The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: As it has been less than year since the CAP – the updated documentation provided for the CAP is still the most current. • HPN_HCO100 10.25.2019 pg 27, 30, 31, 33			

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
• HPN_ADT-01 Elective Adverse Determination Process • HPN_MCD-01 Review Process NV Medicaid			
HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.210(d)(2)(i-ii) *42 CFR §438.404(c)(4)(i)* *42 CFR §438.408(b)(3)* *42 CFR §438.408(c)(1)(i-ii)* *DHCFP Contract Section 3.13.3.2*	15. Expedited Authorization Decisions For cases in which a provider indicates or the MCO determines that following the standard timeframe could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide a notice of action as expeditiously as the recipient's health condition warrants and no later than 72 hours after receipt of the request for service. The MCO may extend the 72 hours' time period by up to 14 calendar days if the recipient requests an extension or if the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the recipient's interest. The MCO must provide written notice of the reason for the extension and inform the recipient of their right to file a grievance.	**Documents Submitted:** IX_HPN_UCSMM.06.16 Initial Review Timeframes pg 5 **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The document, IX HPN UCSMM.06.16 Initial Review Timeframes, contained the time frames and provisions for providing expedited authorization decisions within 72 hours. The policy did not contain provisions for extending the time frame for expedited authorization decisions by 14 calendar days, only for retrospective reviews. HPN staff members confirmed that the language was part of the appeals policy but was not included in the policies that supported expedited authorization decisions. After the on-site visit, HPN staff members provided a letter template that could be sent to members when there is a need to request additional information. The letter template contained language to inform the member that the MCO was extending the decision-making time frame and that the MCO requested information from the member's provider to make a decision regarding the service authorization. The letter also informed the member to file a grievance if the member disagrees with the MCO's plan to collect additional information. The letter template, however, did not specify whether the letter was used for standard authorization decisions or expedited authorization decisions. There was no accompanying policy, procedure, or SOP that described the process for issuing the letter; therefore, it was not clear how staff members were		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	instructed when to issue the letter because it was not clear at the time of the on-site interview that staff members were aware that this letter existed.		
	Recommendations: If the MCO requires an extension of up to 14 additional calendar days to make an expedited authorization decision if the member requests an extension, or if the MCO justifies (to the DHCFP upon request) a need for additional information and how the extension is in the member's interest, the MCO must provide written notice of the reason for the extension and inform the member of the right to file a grievance.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	As mentioned during the on-site, Shawna DeRousse and Serena Siegfried are in the process of updating the health plan's former UM policy – HCO100, which will replace the current UCSMM policies. The HCO 100 policy includes the details regarding requesting the 14 day extension for both standard and expedited authorizations, including the requirements for the written notice to the member. The entire policy is quite lengthy, and is expected to be updated and ready for use by 9/1/19. However, the section of the policy relating to this recommendation (100.05) has been updated, approved, and communicated to staff for use as of August 9, 2019. (see Section 3.7) In addition, the Medical Management department SOPs ADT-01 and MCD-01 (attached) have been updated to reflect the process for requesting extensions for both standard and expedited authorization requests, as well as the requirements for the written response to the member. Shelean Sweet, Director Preservice Review, has communicated these SOP updates to her department as of August 9, 2019.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Elective Adverse Determination Process (Denial), revised on July 29, 2019, and the policy, Review Process for NV Medicaid, revised July 29, 2019 contained the provision that if the MCO needs to extend the timeframe by 14 days to make a routine authorization decision, the MCO sends a notice to the member to inform the member about their right to file a grievance if they disagree with the extension. The policy, Timeliness of UM Decisions-HCO 100.05, revised August 2019 also contained the provision that the MCO provides notice to the member if the MCO requires an extension to make a decision and informs the member of their right to file a grievance if the member disagrees with the extension. HPN staff members confirmed that this section (100.05) of the larger policy has been approved for use as of August 9, 2019 and staff members are aware of the policy. The DHCFP approves this CAP.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
2020 CAP Compliance Review			
MCO Evidence of Compliance: As it has been less than year since the CAP – the updated documentation provided for the CAP is still the most current. • HPN_HCO100 10.25.19 pg 27, 30, 31, 33 • HPN_ADT-01 Elective Adverse Determination Process • HPN_MCD-01 Review Process NV Medicaid			
HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.404(c) *DHCFP Contract Section 3.13.4.5(A-H), 3.13.4.6 and 3.13.4.7*	19. Timing of the Notice of Action The MCO gives notice by the date of the action for the following circumstances: a. In the death of the recipient; b. A signed written recipient statement requesting termination or giving information requiring termination or reduction of services (where the recipient understands that this must be the result of supplying that information); c. The recipient's admission to an institution where he is ineligible for further services; d. The recipient's address is unknown and mail directed to him has no forwarding address; e. The recipient has been accepted for Medicaid services by another local jurisdiction; f. The recipient's physician prescribes the change in level of medical care; g. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions; or h. The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or the resident has not resided in the nursing facility for 30 days (applies only to adverse action for nursing facility transfers);	**Documents Submitted:** IX_HPN_UCSMM.06.16 Initial Review Timeframes IX_HPN_UCSMM.06.18 Initial Adverse Determination Notice IX_HPN_Sample Notice of Action **Description of Process:**	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	i. The MCO must give a notice of action on the date of action when the action is a denial of payment; and, j. The MCO must give notice on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations; and k. Untimely service authorizations constitute a denial and are thus adverse actions.		
	Findings: The policy, UCSMM.06.16 Initial Review Timeframes, detailed the provision to provide NOA at least 10 calendar days before the date of termination, suspension, or reduction of a previously authorized covered service. The provisions detailed in this element, however, were not contained in the policies submitted as evidence. During the on-site review, HPN staff confirmed that the policies submitted as evidence did not detail the circumstances in which a NOA would be provided by the date of the action, as outlined in this element. HPN staff members stated that its policies and procedures related to this requirement would need to be updated.		
	Recommendations: For the circumstances outlined in items a through k of this element, the MCO must give NOA by the date of the action.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	As mentioned during the on-site, Shawna DeRousse and Serena Siegfried are in the process of updating the health plan's former UM policy – HCO100, which will replace the current UCSMM policies. The HCO 100.05 section of the policy includes the details regarding the written notice to the member *on the date of the action*, for circumstances outlined in items a through k of this element. The 100.05 section of the overarching policy has been updated, approved, and communicated to staff for use as of August 9, 2019. See Section 3.3.2.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The policy, Timeliness of UM Decisions-HCO 100.05, revised August 2019 contained the provision to provide notice by the date of action for all the circumstances outlined in a through k of this element.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	The DHCFP approves this CAP.		
2020 CAP Compliance Review			
MCO Evidence of Compliance: *List the title of the documents, including page numbers, that support implementation of the plans of action listed in the Corrective Action Plan section above. A narrative description is not required but can be included to support compliance.* • HPN_HCO100 10.25.2019 pg 27, 30, 31, 33 approved on 10/25/19.			
HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element.			
Required Actions: None.			☒ Met ☐ Not Met

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
42 CFR §438.408(b)(1-3) *42 CFR §438.408(d)(1)* *42 CFR §438.408(d)(2)(i)* *DHCFP Contract Section 3.13.5–3.13.5.3*	20. Handling of Grievances and Appeals The MCO is required to dispose of each grievance and resolve each appeal and to provide notice as expeditiously as the recipient's health condition requires within the State's established time frames specified as follows: a. Standard disposition of grievances: The MCO is allowed no more than 90 calendar days from the date of receipt of the grievance. b. Standard resolution of appeals: The MCO is allowed no more than 30 calendar days from the date of receipt of the appeal. c. Expedited resolution of appeals: The MCO must resolve each expedited appeal and provide notice, as expeditiously as the recipient's health condition requires, not to exceed 72 hours after the MCO receives the expedited appeal request.	**Documents Submitted:** IX_HPN_Appeals Policy IX_HPN_Grievances Policy **Description of Process:**	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The policy, CRR 004.99 Medicaid and Nevada Check Up Appeals Process, provided evidence of HPN's appeal processing procedures, including resolving appeals within the time frames noted in items b and c of this element. The policy, CRR 2018-006 HPN Medicaid Grievance Process, provided evidence of HPN's grievance processing procedures, including resolving grievances within the time frames noted in item a of this element. During the appeal file review, one file contained an expedited appeal that was not resolved within the 72-hour time frame. The MCO made a reasonable effort to provide oral notification to the provider; however, the evidence in the file showed that the appeal was resolved outside of the 72-hour requirement, and there was no evidence to support that the MCO issued a notice to extend the time frame for the appeal decision that includes the reason for the delay.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Recommendations: The MCO must ensure that for expedited resolution for appeals, it resolves expedited appeals and provides notice, as expeditiously as the member's health condition requires, not to exceed 72 hours after the MCO receives the expedited appeal request.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	On July 26, 2019, the Administrative and Prior Authorization Intake teams were provided additional training to identify an appeal and the importance of forwarding the information to the correct department, A&G, in a timely manner. The Utilization Management Associate Director conducted the training. HPN will make every effort to resolve expedited appeals within 72 hours from receipt in company.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP requests a copy of the training materials or other documentation as evidence that the training was performed and verification of the change in practice.		
HPN Response	Training was provided to the team in a meeting on July 26 that included the following direction when documentation is received in the PA Department: • Documents received in the PA Department should be reviewed to identify required action. • If the document is a request for an appeal, fax document to the Appeals Department fax #: 702-266-8813 • Clerical staff may hand-deliver if the document is too large to fax • Clerical staff document appeal on log. • Document is housed in the department (in a secure file) for 6 months This verbal reminder of the current process was understood by the team, and they have demonstrated the steps since the training. To date, all appeals received in the PA department have been handled according to the documented process.		
DHCFP Response (To be completed by DHCFP/HSAG.)	HPN staff members confirmed that a verbal directive was provided to staff members during a meeting. HPN staff members also confirmed that all appeals received in the prior authorization department were processed in accordance with the documented process. The DHCFP accepts this CAP.		

Standard IX: Grievances and Appeals			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
2020 CAP Compliance Review			
MCO Evidence of Compliance: In addition to the verbal reminders provided to the staff during team meetings, an SOP has been created to provide written guidance and documentation of the expectations of appeal requests. • HPN_Admin-05 Document Handling for Appeal Requests			
HSAG Findings: HSAG has determined that the MCO has demonstrated CAP implementation for this element			
Required Actions: None.			☒ Met ☐ Not Met