



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

**State Fiscal Year 2019–2020
Compliance Review**
for
LIBERTY Dental Plan of Nevada, Inc.

December 2020





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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 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 dental benefits administrator (DBA) who is managing dental 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 the DBA's compliance with the federal compliance review standards and the State contract requirements found in the DHCFP Contract 3425. 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 **LIBERTY Dental Plan of Nevada, Inc.**'s (**LIBERTY**'s) compliance with the following:

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

LIBERTY had an overall composite score of 96 percent for all elements evaluated in the SFY 2019–2020 Compliance Review. Additionally, 21 out of 21 CAP elements were determined to be complete, indicating these prior deficiencies were remediated. Based on the findings of the review, **LIBERTY** demonstrated strong compliance with the federal and State requirements contained in its managed care contract.

2. Background

In March 2017, the State of Nevada, Purchasing Division, on behalf of the DHCFP, a Division of the State of Nevada, DHHS, solicited responses from qualified firms to provide DBA services designed in support of the Title XIX (Medicaid) and Title XXI (CHIP—also known as “Nevada Check Up”) medical assistance programs. In response to Request for Proposal (RFP) 3425, the DHCFP contracted with **LIBERTY** to provide dental services to Medicaid and Nevada Check Up recipients.

Mandatory Activity

According to 42 CFR §438.358, which describes the activities related to external quality reviews (EQRs), a state or its EQRO must conduct a review within a three-year period to determine a Medicaid managed care entity’s (MCE’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 MCE 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. For **LIBERTY**, year 1 review standards (i.e., Provider Network Management, Standard 1 through Standard 5) were reviewed as part of the **LIBERTY** Readiness Review, which was completed in November 2017.

Table 2-1—Nevada Compliance Review Cycle for LIBERTY

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 **LIBERTY**'s compliance with federal and State 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 that were found to be deficient in SFY 2018–2019. 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 are compliant.

Compliance Review Process

The compliance standards were derived from the requirements set forth in the *Department of Health and Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3425 for Dental Benefits Administrator*, 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 2019³⁻¹ 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 federal and applicable State regulations and requirements outlined in the contract between the DHCFP and **LIBERTY**. HSAG conducted the following activities as part of the compliance review:

Pre-review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to **LIBERTY** 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 DBA questionnaire.
- Conducting a technical assistance session to assist **LIBERTY** 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 **LIBERTY** 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 **LIBERTY** submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **LIBERTY**'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. *EQR 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 **LIBERTY** used in its operations, which includes, but is not limited to, quality improvement tracking and quality measure reporting.
- Interviews conducted with **LIBERTY**’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 **LIBERTY**’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. In addition, HSAG created a CAP template, shown in Appendix C, which contains the findings and required actions for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, **LIBERTY** must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **LIBERTY** must submit its CAP to the DHCFP **within 30 calendar days of receiving this report.**

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other **LIBERTY** 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, dental health management, and cultural competency.
- The DBA questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with **LIBERTY**’s key staff members during the virtual review.

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

Compliance Standards Reviewed

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

Table 3-1—Compliance Standards

Standard #	Standard Name	Number of Elements
XI	Internal Quality Assurance Program	20
XII	Cultural Competency Program	7
XIII	Confidentiality	11
XIV	Enrollment and Disenrollment	3
Total Number of Elements		41

Data Aggregation and Analysis

Compliance Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which **LIBERTY**'s performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to **LIBERTY** 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 this 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 **LIBERTY** provided to members, HSAG aggregated and analyzed the data resulting from desk and virtual review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing **LIBERTY**'s performance in complying with each standard requirement.
- Scores assigned to **LIBERTY**'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 **LIBERTY** a score for each element and an aggregate score for each standard. Table 4-1 presents **LIBERTY**'s scores for the compliance standards. Details regarding **LIBERTY**'s compliance with the four standards, including the score that **LIBERTY** received for each element within each standard, are found in Appendix A, SFY 2019–2020 Compliance Review Tool for **LIBERTY**.

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	20	20	18	2	0	0	95%
XII	Cultural Competency Program	7	7	6	1	0	0	93%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	3	1	1	0	0	2	100%
Total Compliance Score		41	39	36	3	0	2	96%

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 **LIBERTY** 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 DBA. **LIBERTY** achieved full compliance in two of the four standards reviewed, demonstrating strengths and adherence to all requirements measured in the areas of Confidentiality and Enrollment and Disenrollment.

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

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

CAP Review

LIBERTY was required to submit to the DHCFP a CAP for all elements scored *Partially Met* or *Not Met* in the SFY 2018–2019 compliance review. To ensure the DBA 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 2018–2019 compliance reviews.

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

Table 4-2—Summary of Scores for the SFY 2018–2019 CAP Review

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			<i>M</i>	<i>NM</i>
VI	Member Rights and Responsibilities	NA	NA	NA
VII	Member Information	NA	NA	NA
VIII	Continuity and Coordination of Care	2	2	0
IX	Grievances and Appeals	13	13	0
X	Coverage and Authorization of Services	6	6	0
Total		21	21	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 DBA did not have any deficiencies noted for this standard during the SFY 2018–2019 review.

Of the 21 total elements reviewed, the DBA demonstrated compliance and received a score of *Met* for all elements. Details regarding **LIBERTY**'s compliance with the CAP review are found in Appendix B, 2020 Corrective Action Plan Compliance Review Tool.

Corrective Action Plan

LIBERTY is required to submit to the DHCFP a CAP for all elements scored *Partially Met* or *Not Met*. Appendix C contains the CAP template that HSAG prepared for **LIBERTY** to use in preparing its plans of action to remediate any deficiencies identified during the SFY 2019–2020 Compliance Review, including any elements from SFY 2018–2019 that remained deficient based on the CAP review. The CAP template lists each element for which HSAG assigned a score of *Partially Met* or *Not Met*, as well as the associated findings and required actions documented to bring **LIBERTY** into full compliance with the deficient requirements. **LIBERTY** must use this template to submit its CAP to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s). **LIBERTY**'s CAP must be submitted to the DHCFP **no later than 30 calendar days after receipt of this report**.

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

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

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



Appendix A. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
State Fiscal Year 2019–2020 Compliance Review With Standards Tool
for LIBERTY Dental Plan of Nevada, Inc.



Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
42 CFR §438.330(a)(1) DHCFP Contract Section 3.9.6, 3.9.6.1-2, 3.9.6.4, 3.9.6.5	<p>1. Written IQAP Description</p> <p>The DBA must establish and implement an ongoing comprehensive IQAP.</p> <p>a) <i>The DBA must have a written description of its IQAP.</i></p> <p>b) <i>The written description must contain a detailed set of QA objectives, which are developed annually and include a timetable for implementation and accomplishment.</i></p> <p>c) <i>The written description must provide for continuous performance of the activities, including tracking of issues over time.</i></p> <p>d) <i>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.</i></p>	<p>Documents Submitted:</p> <p>01. 2020 QMI Program Description</p> <p>02. 2020 QMI Work Plan</p> <p>Description of Process:</p> <p>a) See page 4 of the QMI Program</p> <p>b-d) LIBERTY’s QMI Committee develops an annual Work Plan which includes a timetable for implementation and/or completion of activities and objectives in the new year. The Work Plan includes metrics that will be tracked and monitored on a quarterly and/or annual basis.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendations: HSAG recommends that the DBA review its annual Internal Quality Assurance Program (IQAP) evaluation and ensure it is not inclusive of other lines of business (LOBs). The DBA should also consider creating an IQAP description and work plan specific to the Nevada Medicaid LOB. Additionally, in review of the DBA’s policies, many were noted to be recently “Issued” and/or “Approved,” causing concern that the DBA did not have the appropriate policies in place during the review period. However, discussion suggested that the “Approved” date is also intended to mean a review or revision of the policy. DBA staff members indicated that some policies are replacing previous versions that were in place. HSAG recommends that the DBA review its policy template and process for creating, revising/reviewing, or retiring policies and how</p>			

^{A-1} The Information Submitted as Evidence by the DBA column was completed by the DBA and has not been altered by HSAG except for minor formatting.



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	<p>it is documented. The DBA should consider the use of terminology that accurately reflects the action; for example, “Issued,” “Approved,” “Reviewed,” “Revised,” etc. There should be clear documentation of when a new policy replaces a retired policy.</p> <p>Required Actions: None.</p>		
<p>42 CFR §438.330(a)(1) DHCFP Contract Section 3.9.6.3(A-B)</p>	<p>2. Scope</p> <p>a) <i>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.</i></p> <p>b) <i>The IQAP methodology must provide for review of the entire range of care provided by the DBA, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.</i></p>	<p>Documents Submitted:</p> <p>01. 2020 QMI Program Description</p> <p>Description of Process:</p> <p>a) See page 6 of the QMI Program</p> <p>b) See page 4 of the QMI Program</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
	<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendations: HSAG recommends that the DBA clearly define its CSHCN population in its IQAP description. This should align with the State’s definition.</p> <p>Required Actions: None.</p>		
<p>42 CFR §438.330(b)(3) DHCFP Contract Section 3.9.8.1(D)</p>	<p>3. Over and Under-Utilization of Services</p> <p>The comprehensive IQAP must include mechanisms to asses both underutilization and overutilization of services, and to follow up appropriately.</p> <p>a) <i>If fraud and abuse is suspected, a referral must be made to the DBA’s PIU and the DHCFP SUR Unit for appropriate action.</i></p>	<p>Documents Submitted:</p> <p>03. 2020 Utilization Management Program</p> <p>04. SIU PP - SIU Fraud and Abuse Referrals – NEVADA</p> <p>Description of Process:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
		LIBERTY’s Utilization Management Committee reviews and assesses utilization data to identify service patterns and/or trends of over and under-utilization that require intervention. The UM Committee may also refer to LIBERTY’s Special Investigation Unit any suspected instances of fraud, waste or abuse for reporting to the DHCFP’s SUR Unit for appropriate action.	
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			
42 CFR §438.330(b)(4) DHCFP Contract Section 3.9.8.3(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. <i>a) Multi-disciplinary teams are required, when appropriate, to analyze and address systems issues.</i>	Documents Submitted: 05. QM PP - Coordination of Dental Services - NEVADA Description of Process: See pages 2-3 of the policy QM PP – Coordination of Dental Services - NEVADA	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Recommendation: HSAG recommends that the DBA clearly define its special health care needs population in its IQAP. This should align with the State’s definition.			
Required Actions: None.			



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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
42 CFR §438.330(c)(2) (i-iii) DHCFP Contract Section 3.9.3.1, 3.9.3.2	5. Performance Measurement The DBA must annually: <ul style="list-style-type: none"> a) Measure and report to DHCFP on its performance, using standard measures required by DHCFP. b) Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the DBA's performance using the standard measures identified by DHCFP 	Documents Submitted: 06. NV PIP Improve Annual Dental Visit Modules 07. NV PIP Improve Caries Risk Assessment Modules Description of Process: LIBERTY's current process for Performance Measurement on Performance Improving Projects involves guidance and approval from DHCFP's External Quality Reporting Organization, Health Services Advisory Group, Inc. (HSAG). LIBERTY ensures that HSAG approves each PIP progress before final submission.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.9.8.1	6. Quality Indicators <i>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 DBA is required to:</i>	Documents Submitted: 08. UM PP - Provider Profiling Description of Process: See pages 2-4 of the policy UM PP – Provider Profiling	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
	<p>a) <i>Identify and use quality indicators that are objective, measurable, and based on current knowledge and clinical experience.</i></p> <p>b) <i>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.</i></p> <p>c) <i>Ensure methods and frequency of data collection; ensure data accuracy; and ensure data is effective and sufficient to detect the need for program change.</i></p>		
<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendations: While performance goals or benchmarks for some activities were included in the annual IQAP evaluation, HSAG recommends that the DBA consider identifying and including objective and measurable goals in its IQAP work plan. A column titled “Goal/Objective” is included in the work plan; however, no goal or objective was identified for many activities. Instead, the DBA used this column to document what appears to be a time frame for reviewing the activity (e.g., “Annual” or “Quarterly”). The DBA should enhance processes to identify goals following the SMART (specific, measurable, attainable, relevant, and time-based) framework. The annual program evaluation should coincide with those goals identified in the work plan.</p>			
<p>Required Actions: None.</p>			
<p>42 CFR §438.330(b)(4) DHCFP Contract Section 3.9.7.5-6</p>	<p>7. Performance Improvement Projects (PIPs)</p> <p>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 member satisfaction, and must include the following elements:</p> <p>a) Measurement of performance using objective quality indicators.</p>	<p>Documents Submitted:</p> <p>06. NV PIP Improve Annual Dental Visit Modules</p> <p>07. NV PIP Improve Caries Risk Assessment Modules</p> <p>09. Q3 2019 - QMI Committee - Nevada PIPs</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
	b) Implementation of interventions to achieve improvement in quality. c) Evaluation of the effectiveness of the interventions. d) Planning and initiation of activities for increasing or sustaining improvement.	10. Q4 2019 - QMI Committee - Nevada PIPs Description of Process: LIBERTY’s current process for Performance Improvement Projects relies on working with DHCFP’s External Quality Reporting Organization, Health Services Advisory Group, Inc. (HSAG) by using their rapid-cycle PIP process. HSAG guides LIBERTY in validating performance improvement projects (PIPs) that place greater emphasis on improving both healthcare outcomes and healthcare disparities through the integration of quality improvement projects. This allows LIBERTY to conduct PIPs using a rapid-cycle improvement method to pilot small changes rather than implementing one large transformation. By piloting on a smaller scale, LIBERTY will have an opportunity to determine the effectiveness of several changes prior to expanding the successful interventions to a larger scale.	



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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
		<p>HSAG developed a series of five modules to guide LIBERTY through the whole PIP process from start to completion. This process allows LIBERTY and HSAG to establish a quality driven framework that boosts LIBERTY’s Quality Improvement Projects.</p> <p>LIBERTY’s QMI Committee also monitors the updates and submissions of PIPs quarterly.</p>	
<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendation: HSAG recommends that the DBA create a policy, or add to its IQAP the DBA’s internal PIP methodology to be followed when conducting internal PIPs.</p>			
<p>Required Actions: None.</p>			
<p>42 CFR §438.330(d)(3) DHCFP Contract Section 3.9.2, 3.9.7.4</p>	<p>8. Implementation of PIPs</p> <p>The DBA must report the status and results of each project to DHCFP as requested, including those that incorporate the requirements of 42 CFR §438.330.</p> <p><i>Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects to be available to the DHCFP for its annual review of the vendor’s quality assessment and improvement program.</i></p>	<p>Documents Submitted:</p> <p>06. NV PIP Improve Annual Dental Visit Modules</p> <p>07. NV PIP Improve Caries Risk Assessment Modules</p> <p>09. Q3 2019 - QMI Committee - Nevada PIPs</p> <p>10. Q4 2019 - QMI Committee - Nevada PIPs</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
	<p>a) <i>The DBA is required to annually conduct and report on a minimum of one clinical PIP and one non-clinical PIP.</i></p> <p>b) <i>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.</i></p>	<p>Description of Process:</p> <p>LIBERTY’s current process for Performance Improvement Project implementation, relies on working with DHCFP’s External Quality Reporting Organization, Health Services Advisory Group, Inc. (HSAG) and following their structured guidelines and instruction for the rapid-cycle PIP process. Per HSAG, “rapid-cycle PIP processes require up-front preparation to allow for a more structured, scientific approach to quality improvement. It is imperative that each MCO tracks the project throughout the PIP duration. The PIP process is structured into four phases, and in most cases a PIP will last from 12 to 18 months. In the first (initiation) phase, HSAG worked with LIBERTY and the State to determine the timeline for the four phases and LIBERTY has been successful in completing all Modules timely and the current status on both PIPs (Improving Annual Dental Visits and</p>	



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		Improving Caries Risk Assessments) is submission of Modules 4 and 5 in which we are awaiting feedback from HSAG. LIBERTY’s QMI Committee also monitors the updates and submissions of PIPs quarterly.	
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			
42 CFR §438.330(e)(2) DHCFP Contract Section 3.9.8.7	<p>9. Program Evaluation</p> <p>The DBA must develop a process to evaluate the impact and effectiveness of its own IQAP.</p> <ul style="list-style-type: none"> a) The vendor 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 the DHCFP 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; and c) The report should include evidence that quality assurance activities have contributed to significant improvements in the care delivered to members. 	<p>Documents Submitted:</p> <p>11. 2019 QMI Annual Program Evaluation - NV_FINAL</p> <p>Description of Process:</p> <p>Annually, LIBERTY completes an evaluation of the Quality Management and Improvement Program to assess the oversight of the QMI Program, clinical guidelines, completion of QMI Work Plan metrics, process improvement initiatives, and the overall effectiveness of the QMI Program.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
	<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendations: For some activities, while the DBA may have presented data, it did not conduct, or did not document in the IQAP evaluation, a thorough analysis of the results of those activities. For example, under the “Analysis” heading, the DBA included an overview of a process as opposed to a summary of the analysis of the results of the activity. This process does not provide meaningful and necessary information to evaluate the effectiveness of the IQAP and promote quality improvement, and the language is more appropriate for an IQAP description. HSAG strongly suggests that the DBA reexamine its approach for conducting and documenting a thorough analysis of all activities included in its IQAP evaluation.</p>		
	<p>Required Actions: None.</p>		
<p><i>DHCFP Contract Section 3.9.6.6(A-B)</i></p>	<p>10. Provider Review</p> <ul style="list-style-type: none"> a) Dentists and other health professionals review the process followed in the provision of dental services and outcomes. b) The DBA must provide feedback to health professionals and DBA staff regarding performance and patient health care outcomes. 	<p>Documents Submitted:</p> <ul style="list-style-type: none"> 12. 2020 Dental Advisory Committee Charter 13. 2020 Peer Review Committee Charter 14. QM PP - Peer Review Committee Process <p>Description of Process: LIBERTY’s Dental Advisory Committee as well as the Peer Review Committee identifies areas in which LIBERTY Providers are involved in the discussion, feedback, and performance of the overall QMI Program.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	<p>Findings: The DBA provided limited information to confirm that it provides feedback to health professionals and providers regarding performance and member healthcare outcomes outside of the external providers that happen to be present on the Dental Advisory Committee or Peer Review Committee. After the virtual review, the DBA provided an example of a provider</p>		



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	<p>newsletter with a narrative explaining that it had identified that providers often submit incomplete dental records for case reviews and, therefore, an article was published in the newsletter to remind providers of the importance of submitting complete dental records. However, this does not demonstrate that the DBA provided feedback on performance or member outcomes, either at the DBA level or provider-specific level. HSAG noted that the Utilization Management Program Description suggested that the DBA is profiling providers and sharing this feedback with providers. HSAG requested evidence to verify this was actually occurring and no provider profiles, or evidence that provider profiles were communicated to providers, were submitted. HSAG does acknowledge that the DBA discovered that the additional documentation requested for this element was not submitted to the HSAG portal due to a manual uploading error and was later uploaded; however, this evidence was not considered as it was received after the submission due date.</p> <p>Required Actions: The DBA must provide feedback to health professionals and DBA staff members regarding performance and patient healthcare outcomes. The DBA also must provide practice feedback to practitioners.</p>		
<p><i>DHCFP Contract Section 3.9.8.4, 3.9.8.5 (A-F)</i></p>	<p>11. Implementation of Corrective Actions</p> <p><i>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:</i></p> <ul style="list-style-type: none"> <i>a) Specification of the types of problems requiring corrective action.</i> <i>b) Specification of the person(s) or body responsible for making the final determinations regarding quality problems.</i> <i>c) Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff.</i> <i>d) The schedule and accountability for implementing corrective actions.</i> <i>e) The approach to modifying the corrective action if improvements do not occur.</i> 	<p>Documents Submitted:</p> <p>15. QM PP - Corrective Action Quality Improvement and Follow-Up</p> <p>16. QM PP - Potential Quality Issue (PQI) Process</p> <p>Description of Process:</p> <p>LIBERTY implements numerous activities to monitor and identify areas needing improvement. Corrective Action Plans (CAP) are developed, issued, and implemented when quality of care issues or opportunities for improvement are identified,</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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	<i>f) Procedures for terminating the affiliation with the physician, or other health professional or provider.</i>	inappropriate or substandard services are delivered, or services that should have been provided were not. CAPS are tracked accordingly to ensure interventions were effective.	
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			
<i>DHCFP Contract Section 3.9.8.6(A-B)</i>	12. Assessment of Effectiveness of Plans of Correction (POC) <i>a) As actions are taken to improve care, there is monitoring and evaluation including a POC to assure required changes have been made. In addition, changes in practice patterns are monitored.</i> <i>b) The DBA assures follow-up on identified issues to ensure actions for improvement have been effective.</i>	Documents Submitted: 15. QM PP - Corrective Action Quality Improvement and Follow-Up Description of Process: LIBERTY implements numerous activities to monitor and identify areas needing improvement. Corrective Action Plans (CAP) are monitored and tracked accordingly to ensure interventions were effective.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			



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<i>DHCFP Contract Section 3.9.9</i>	13. Accountability to the Governing Body <i>The Governing Body of the DBA 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 DBA is responsible for the DBA's IQAP review.</i> a) <i>There is documentation that the Governing Body has approved the overall IQAP and the annual IQAP.</i> b) <i>The Governing Body has formally designated an entity or entities within the DBA 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.</i> c) <i>The Governing Body routinely receives written reports from the IQAP describing actions taken, progress in meeting quality assurance objectives, and improvements made.</i>	Documents Submitted: 01. 2020 QMI Program Description Description of Process: LIBERTY's Dental Director and QMI Committee is responsible for the annual review of the QMI Program and its activities. The results of the annual review are documented and reported directly to the Board of the Directors.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element. However, HSAG requested two examples of Board of Directors (BOD) meeting minutes and/or BOD written reports; however, only one was provided. After the virtual review, HSAG requested a second example. The DBA provided dashboard examples and Nevada Market Meeting minutes, all of which were dated outside of the time period of review. Additionally, it was unclear if the Nevada Market Meeting is equivalent to the BOD as its meeting minutes do not coincide with the topics included in the Quarterly Meeting of the Board of Directors example. Further, should the Nevada Market Meeting coincide with the BOD, agenda items included in the Nevada Market Meeting and level of detail in meeting minutes appeared inadequate for a BOD meeting. As the DBA received a <i>Partially Met</i> score for this same finding for Element 16, the DBA received a <i>Met</i> score for this element. Refer to Element 16 for more details.		
	Required Actions: None.		



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<i>DHCFP Contract Section 3.9.9.5 (A-D)</i>	14. Annual IQAP Review <i>The Governing Body formally reviews on a periodic basis, but no less frequently than annually, a written report on the IQAP. This quality program evaluation report is submitted to DHCFP annually in the second calendar quarter and at minimum includes:</i> <ol style="list-style-type: none"> <i>Studies undertaken.</i> <i>Results.</i> <i>Subsequent actions and aggregate data on utilization and quality of services rendered; and</i> <i>An assessment of the IQAPs continuity, effectiveness, and current acceptability.</i> 	Documents Submitted: 11. 2019 QMI Annual Program Evaluation - NV_FINAL Description of Process: Annually, LIBERTY completes an evaluation of the Quality Management and Improvement Program to assess the oversight of the QMI Program, clinical guidelines, completion of QMI Work Plan metrics, process improvement initiatives, and the overall effectiveness of the QMI Program.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element. Recommendations: While the IQAP program description confirmed it was approved by the BOD, it was not clear that the BOD also approved the annual IQAP evaluation. DBA staff members clarified that the approval page on the IQAP description was intended to also mean the approval of the annual IQAP evaluation. BOD approval of the annual IQAP evaluation was not clearly identified in meeting minutes. As such, HSAG recommends that the DBA enhance its documentation of BOD approval of IQAP documents in meeting minutes and/or a signature page of the IQAP documents (description, work plan, and evaluation).		
	Required Actions: None.		
<i>DHCFP Contract Section 3.9.9.6</i>	15. Program Modification <i>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</i>	Documents Submitted: 11. 2019 QMI Annual Program Evaluation - NV_FINAL	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p><i>ongoing basis to accommodate review findings and issues of concern with the DBA. 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.</i></p>	<p>Description of Process: LIBERTY’s QMI Program document and the effectiveness of the program is reviewed, evaluated and revised on an annual basis. The annual evaluation, revised program and work plan activities are submitted to the QMI Committee of LIBERTY Dental for review, input and reporting to the Board of Directors for approval. The QMI Committee is presented with the evaluation report, which is reviewed to formulate recommendations for continuous process improvement revisions. After the revisions have been approved, they are formally presented to the Board of Directors for review and approval.</p>	
<p>Findings: HSAG requested two examples of BOD meeting minutes to confirm compliance with providing the BOD with regular written reports. One example of what appeared to be a memo including an executive summary of a quarterly BOD meeting was submitted. After the virtual review, HSAG requested a second example. The DBA provided dashboard examples and Nevada Market Meeting minutes, all of which were dated outside of the time period of review. Additionally, it was unclear if the Nevada Market Meeting is equivalent to the BOD as its meeting minutes do not coincide with the topics included in the executive summary memo that was provided. Further, should the Nevada Market Meeting coincide with the BOD, agenda items included in the Nevada Market Meeting and level of detail in meeting minutes appeared inadequate for a BOD meeting. It was unclear if the executive summary memo is intended to represent meeting minutes, as it appears to be a summary of activities, but no</p>			



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	<p>minutes of discussion items. There was no documented follow-up discussion regarding any of the information provided within the report to the BOD in the Nevada Market Meeting minutes.</p> <p>Required Actions: The DBA must provide the BOD with 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 DBA. This activity must be documented in the minutes of the meetings of the BOD in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.</p>		
<p><i>DHCFP Contract Section 3.9.10</i></p>	<p>16. Active QA Committee</p> <p><i>The IQAP must delineates an identifiable structure responsible for performing quality assurance functions within the DBA. This committee or other structure must have:</i></p> <ul style="list-style-type: none"> <i>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.</i> <i>b) The role, structure and function of the structure/committee must be specified.</i> <i>c) There must be records documenting the structure and committee’s activities, findings, recommendations and actions.</i> <i>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.</i> <i>e) There must be active participation in the IQAP committee from DBA providers, who are representative of the composition of the DBA’s providers.</i> 	<p>Documents Submitted:</p> <p>17. QM PP - Quality Management and Improvement Program and Committee</p> <p>01. 2020 QMI Program Description</p> <p>Description of Process:</p> <p>LIBERTY’s quality improvement resources are designed to meet its member’s needs and to effectively carry out all designated QMI Program functions including the development, implementation and evaluation of quality improvement program activities. The senior leadership of LIBERTY consists of experienced, well-qualified administrative and clinical leaders</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
		with a commitment to the delivery of quality care and service.	
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			
<i>DHCFP Contract Section 3.9.11</i>	17. IQAP Supervision There is a designated senior executive who is responsible for IQAP implementation. The DBA’s Dental Director has involvement in QA activities.	Documents Submitted: 18. QM PP - Dental Director Oversight 17. QM PP - Quality Management and Improvement Program and Committee Description of Process: LIBERTY has appropriately licensed Dental Director(s) that are responsible for the oversight, development, implementation, and review of LIBERTY’s Quality Management and Improvement (QMI) Program, Committees, Work Groups and related activities	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			



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<i>DHCFP Contract Section 3.9.12</i>	18. Adequate Resources The IQAP has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.	Documents Submitted: 19. QM PP - QM_UM Staff Qualifications Description of Process: LIBERTY ensures adequate and experienced personnel for conducting all Quality Improvement Program activities. The Staff shall demonstrate clinical experience, when applicable, and are familiar with dental managed care and government programs.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
<i>DHCFP Contract Section 3.9.13</i>	19. Provider Participation in IQAP a) <i>Participating physicians and other providers must be kept informed about the written IQAP through provider newsletters and updates to the provider manual.</i> b) <i>The DBA must include in its provider contracts and employment agreements, for dentists and non-dental providers, a requirement securing cooperation with the IQAP.</i> c) <i>Contracts must specify that hospitals and other vendors will allow the DBA access to the dental records of its members.</i>	Documents Submitted: 20. NV Provider Agreement 21. Nevada Medicaid Program Addendum 22. QM PP - Provider Education Training Description of Process:	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Reference	Requirement	Information Submitted as Evidence by the DBA ^{A-1}	Score
		LIBERTY’s provider contract is distributed to all providers upon contracting and includes provisions to ensure provider cooperation with our Quality Improvement Program and activities. LIBERTY also directly contracts with licensed dental professionals. Our provider contracts allow us to access dental records for our members.	
	<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendations: While the provider newsletter included general information on various topics that may relate to or impact the IQAP in general terms, HSAG recommends that the DBA include more specific information on the IQAP, such as the DBA’s performance of quality activities and initiatives.</p> <p>Required Actions: None.</p>		
<i>DHCFP Contract Section 3.9.22.1</i>	<p>20. Coordination of QA Activities with Other Management Activity</p> <p><i>The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported within the DBA’s organization and through the established QA channels.</i></p> <p>a) <i>Quality assurance information is used in credentialing, recredentialing, and/or annual performance evaluations.</i></p> <p>b) <i>Quality assurance activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of member grievances and appeals.</i></p>	<p>Documents Submitted:</p> <p>01. 2020 QMI Program Description</p> <p>11. 2019 QMI Annual Program Evaluation - NV_FINAL</p> <p>Description of Process:</p> <p>LIBERTY’S Annual Program Evaluation is an annual summary of the QMI Program in which document the findings, actions</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>c) <i>There is a linkage between quality assurance and the other management functions of the DBA such as:</i></p> <ul style="list-style-type: none"> i. <i>Network changes.</i> ii. <i>Benefits redesign.</i> iii. <i>Medical management systems (e.g., pre-certification).</i> iv. <i>Practice feedback to practitioners.</i> v. <i>Patient education.</i> vi. <i>Member services.</i> 	<p>taken (if applicable), and process improvements reported throughout the calendar year to the QMI Committee.</p> <p>LIBERTY’s QMI Program also includes standards, policies and procedures for credentialing and re-credentialing dentists as well as a Peer Review Committee that is utilized to conduct quality of care oversight, which includes utilization review metrics, complaints and grievances, in compliance with applicable state and federal laws and regulations.</p>	
<p>Findings: HSAG has determined that the DBA has met the requirements for this element. While the DBA did not provide evidence that it provided practice feedback to practitioners, the DBA received a <i>Partially Met</i> score for a similar finding for Element 10 and therefore received a <i>Met</i> score for this element. Refer to Element 10 for details. Additionally, while the DBA demonstrated that quality assurance information was used in credentialing as required by this element, the DBA should be prepared to demonstrate a review of data from grievances and appeals; results of quality reviews; utilization management; member satisfactions surveys during future reviews of recredentialing files as required under Contract 3.9.15.6(C).</p>			
<p>Required Actions: None.</p>			



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Results for Standard XI: Internal Quality Assurance Program				
Total Elements	Met	= 18	X	1.00 = 18.00
	Partially Met	= 2	X	.50 = 1.00
	Not Met	= 0	X	.00 = .00
	Not Applicable	= 0	X	.00 = .00
Total Applicable		= 20	Total Rate	= 19.00
Total Rate ÷ Total Applicable = Total Score				95%



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Standard XII: Cultural Competency Program			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.206(c)(2) DHCFP Contract Section 3.3.1.12, 3.6.2.8	1. Culturally Competent Delivery of Services <i>The DBA must participate in State and federal efforts to promote the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds pursuant to the Medicaid Service Manual (MSM) chapter 100. The DBA is required to offer accessible and high quality services in a culturally competent manner.</i>	Documents Submitted: 01. CU PP – Cultural and Linguistic Competency Program Compliance 01a.CU PP - Cultural and Linguistic Competency Program Compliance - APPENDIX A - Readability Level Description of Process: See attached P&P for description of process.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
DHCFP Contract Section 3.3.4	2. Health Promotion and Education <i>The DBA shall identify relevant community issues and health promotion and education needs of its members, through the use of community-based needs assessments and other relevant information, and implement plans that are culturally appropriate to meet those identified needs and issues relevant to each of the target population groups of members served.</i>	Documents Submitted: 02. CU PP – Monitoring of Membership Demographics Description of Process: See attached P&P for description of process.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
<i>DHCFP Contract Section 3.10.2.2 (A)(2)</i>	3. Cultural Competency Plan (CCP) <i>The DBA is required to develop a CCP that includes methods to encourage culturally-competent contact between members and providers, staff recruitment, staff training, translation services, and the development of appropriate health education materials.</i>	Documents Submitted: 03. 2019 Cultural and Linguistic Competency Program 04. 2019 Cultural and Linguistic Competency WorkPlan Description of Process: See attached P&P for description of process.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
<i>42 CFR §438.206(c)(2)</i> <i>DHCFP Contract Section 3.10.2.2 (A)(2)</i>	4. Cultural Competency Plan <i>The DBA is responsible for promoting the delivery of services in a culturally competent manner, solely determined by the DHCFP, to all members including those with limited English proficiency (LEP) and diverse cultural and ethnic background.</i>	Documents Submitted: 03. 2019 Cultural and Linguistic Competency Program 04. 2019 Cultural and Linguistic Competency WorkPlan Description of Process: See attached P&P for description of process.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
<i>DHCFP Contract Section 3.10.2.2 (A)(2)</i>	5. Primary Language Tracking <i>The DBA will develop methods to collect report and identify the race, ethnicity, and primary language spoken of each enrolled</i>	Documents Submitted: 02. CU PP – Monitoring of Membership Demographics Description of Process:	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Required Actions: None.		



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Standard XII: Cultural Competency Program			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	<i>member. The DBA will track primary language information in its customer services systems.</i>	See attached P&P for description of process.	
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			
DHCFP Contract Section 3.10.2.2 (A)(2)	6. Interventions to Reduce Health Care Disparities <i>The DBA will organize interventions specifically designed to reduce or eliminate disparities in health care.</i>	Documents Submitted: 05. CU SOP - Identifying Health Disparities and Interventions Description of Process: See attached P&P for description of process.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			
42 CFR §438.10(h)(1)(vii)	7. Information for all Members The DBA must make available in paper form upon request and electronic form, information about its network providers that includes the providers' cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.	Documents Submitted: 06. NM PP – Maintaining Provider Directories 07. QM PP – Provider Education Training Description of Process: See attached P&P for description of process.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: During the virtual review, LIBERTY staff members stated that information about whether a provider had completed cultural competence training was included in the member handbook. The member handbook included language/s spoken by the provider; however, it did not identify whether a provider had completed cultural competence training. Further,			



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Standard XII: Cultural Competency Program			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	the online provider directory did not identify if the provider received cultural competency training as required by federal regulation.		
	Required Actions: The DBA must identify in the provider directory if the provider received cultural competency training as required in federal regulation.		

Results for Standard XII: Cultural Competency Program				
Total Elements	Met	= 6	X 1.00	= 6.00
	Partially Met	= 1	X .50	= .50
	Not Met	= 0	X .00	= .00
	Not Applicable	= 0	X .00	= .00
	Total Applicable	= 7	Total Rate	= 6.50
Total Rate ÷ Total Applicable = Total Score				93%



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Standard XIII: Confidentiality			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
<p>42 CFR §438.224 45 CFR parts 160 and subparts A and E of 164 DHCFP Contract Section 3.9.16.9, 3.9.16.9 (A)</p>	<p>1. Confidentiality of Member Information</p> <p>The DBA 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.</p> <p>a) <i>The DBA acts to ensure that the confidentiality of specified member information and records is protected.</i></p> <p>b) <i>The DBA must establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of dental records.</i></p>	<p>Documents Submitted:</p> <ol style="list-style-type: none"> HA PP – Uses & Disclosure of Protected Health Information – General Rules HA PP – Confidentiality and Release of Information <p>Please see highlighted portions of:</p> <ol style="list-style-type: none"> HA PP - Administrative Requirements – HIPAA Privacy Program LIBERTY Employee Handbook <p>Description of Process:</p> <p>a) LIBERTY’s <i>Uses & Disclosure of Protected Health Information – General Rules and Confidentiality and Release of Information</i> policies establish LIBERTY’s standards for ensuring the confidentiality of specified member information and records is protected.</p> <p>b) LIBERTY’s <i>Administrative Requirements – HIPAA Privacy Program</i> policy requires that LIBERTY establish and maintain formal policies and procedures on confidentiality, including confidentiality of dental records. Both this policy and</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>



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Standard XIII: Confidentiality			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
		LIBERTY's <i>Employee Handbook</i> , set forth standards for enforcement of LIBERTY's confidentiality policies.	
<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Recommendations: Although the DBA's Notice of Privacy Practices was included as a link to the Member Handbook, the date on the notice was 2016. HSAG recommends that the DBA conduct a formal review of the Notice of Privacy Practices annually and update the notice with a reviewed and/or revised date. Additionally, although the DBA provided comprehensive documentation to support staff training, the DBA should revise the Request and Disclosure Table within the Compliance Training document to differentiate between minor and adult children.</p> <p>Required Actions: None.</p>			
42 CFR §438.224 DHCFP Contract Section 3.9.16.9 (B)	<p>2. Office Sites Maintaining Confidentiality of Patient Information</p> <p><i>The DBA must ensure that patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the DBA.</i></p>	<p>Documents Submitted:</p> <p>Please see highlighted portions of</p> <ul style="list-style-type: none"> 5. Nevada Medicaid Provider Agreement 6. Nevada Medicaid Provider Reference Guide <p>Description of Process:</p> <p>Through our <i>Provider Agreement</i> and <i>Provider Reference Guide</i> we establish the standards our providers must adhere to with regard to ensuring that patient care offices/sites have mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p> <p>Required Actions: None.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.224 DHCFP Contract Section 3.9.16.9 (C)(1-3)	3. Releasing Confidentiality of Member Information <i>The DBA 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:</i> <ol style="list-style-type: none"> a) <i>It is required by law, or pursuant to a hearing request on the member’s behalf;</i> b) <i>It is necessary to coordinate the member’s care with other dental care providers, physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; or</i> c) <i>It is necessary in compelling circumstances to protect the health or safety of an individual.</i> 	Documents Submitted: <ol style="list-style-type: none"> 1. HA PP - Uses and Disclosure of Protected Health Information - General Rules 2. HA PP – Confidentiality and Release of Information 7. HA PP - Uses and Disclosures of PHI for which Authorization or Opportunity to Object is Not Required Description of Process: The above referenced policies each set forth the standards LIBERTY adheres to with regard to holding confidential all information obtained by LIBERTY personnel about members related to their examination, care and treatment. These policies prohibit LIBERTY from divulging confidential member information without the member’s authorization, except for certain specific circumstances, consistent with applicable law.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: HSAG has determined that the DBA has met the requirements for this element.			
Required Actions: None.			



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Standard XIII: Confidentiality			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.224 45 CFR §164.410	4. Reporting Inappropriate Use and Disclosure of Protected Health Information (PHI) to DHCFP The DBA 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 DBA has knowledge of or reasonably should have knowledge of under the circumstances.	Documents Submitted: 8. Incident Management Plan - Appendix B - Notification to Covered Entity of a Breach or Security Incident Description of Process: The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.224 DHCFP Contract Section 3.9.16.9 (E)	5. Requirements for Confidentiality of Member Information <i>The DBA may disclose member records whether or not authorized by the member, to qualified personnel, defined as persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State agency.</i>	Documents Submitted: 1. HA PP – Uses & Disclosure of Protected Health Information – General Rules 2. HA PP – Confidentiality and Release of Information 3. HA PP - Uses and Disclosures of PHI for which Authorization or Opportunity to Object is Not Required Description of Process: The above referenced policies set forth this standard.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
45 CFR §164.404(a)	6. Discovery of a Breach The DBA, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the DBA to have been accessed, acquired, used, or disclosed as a result of such breach.	Documents Submitted: 9. Incident Management Plan - Appendix A - Notification in the case of Breach of Unsecured Protected Health Information Description of Process: The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
	7. Timeliness of Notification Except as provided in §164.412 (law enforcement delay), the DBA 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: Incident Management Plan - Appendix A - Notification in the case of Breach of Unsecured Protected Health Information Description of Process: The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
45 CFR §164.404(c)(1-2)	<p>8. Content of Notification</p> <p>The notification required by paragraph (a) of this section shall include, to the extent possible:</p> <ul style="list-style-type: none"> 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, website, or postal address. f) Shall be written in plain language. 	<p>Documents Submitted:</p> <p>9. Incident Management Plan - Appendix A - Notification in the case of Breach of Unsecured Protected Health Information</p> <p>Description of Process:</p> <p>The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p>		
	<p>Required Actions: None.</p>		



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Standard XIII: Confidentiality			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
45 CFR §164.404(d)(1)(i-ii)	<p>9. Method of Notification</p> <p>The notification shall be provided in the following form:</p> <p>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.</p> <p>b) If the DBA 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.</p>	<p>Documents Submitted:</p> <p>9. Incident Management Plan - Appendix A - Notification in the case of Breach of Unsecured Protected Health Information</p> <p>Description of Process:</p> <p>The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> N/A
	<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p>		
	<p>Required Actions: None.</p>		
45 CFR §164.404(d)(2)	<p>10. Substitute Notice</p> <p>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.</p> <p>a) Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact</p>	<p>Documents Submitted:</p> <p>9. Incident Management Plan - Appendix A - Notification in the case of Breach of Unsecured Protected Health Information</p> <p>Description of Process:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	<p>information that precludes written notification to the next of kin or personal representative of the individual under paragraph (d)(1)(i).</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the website 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. 	<p>The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.</p>	
<p>Findings: HSAG has determined that the DBA has met the requirements for this element.</p>			
<p>Required Actions: None.</p>			



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Standard XIII: Confidentiality			
Reference	Requirement	Information Submitted as Evidence by the DBA	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 DBA may provide information to individuals by telephone or other means, as appropriate.	Documents Submitted: 9. Incident Management Plan - Appendix A - Notification in the case of Breach of Unsecured Protected Health Information Description of Process: The above referenced Appendix to LIBERTY’s Incident Management Plan sets forth this standard.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA 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%	



Appendix A. Division of Health Care Financing and Policy
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Standard XIV: Enrollment and Disenrollment			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
DHCFP Contract Section 3.4.1	1. Eligibility and Enrollment Functions <i>The DBA shall establish and implement enrollment procedures and maintain applicable enrolled member data.</i>	<p>Documents Submitted:</p> <ul style="list-style-type: none"> 01. EE PP - Enrollment Guidelines 02. EE PP - Capitated Provider to Member Assignments 03. 834 Data Interfaces Flowchart 04. EE PP - Timely Uploading and Reconciliation of Electronic Eligibility Files <p>Description of Process: See attachment 04. EE PP - Timely Uploading and Reconciliation of Electronic Eligibility Files</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG has determined that the DBA has met the requirements for this element.		
	Required Actions: None.		
42 CFR §438.56(b)(2)	2. Disenrollment at the Request of the DBA <i>The DBA may request disenrollment of a member if the continued enrollment of the member seriously impairs the DBA’s ability to furnish service to either the particular member or other members.</i>	<p>Documents Submitted:</p> <ul style="list-style-type: none"> 5. QM PP - Disenrollment Process <p>Description of Process: See attachment: 5. QM PP - Disenrollment Process</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> N/A
	Findings: The DBA’s contract with the DHCFP did not specify the reasons the DBA can request disenrollment of a member. The Member Handbook did indicate that a member will be automatically disenrolled if he or she is no longer eligible for		



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Standard XIV: Enrollment and Disenrollment			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	<p>Medicaid, moves to a part of the State not covered by an MCO, or opts out of an MCO. Further, the Member Handbook included the phone number for the Nevada Medicaid District Office for any questions about enrollment or disenrollment. During the virtual review, the DBA indicated the disenrollment form attached to the RFP was not applicable to the DBA per the DHCFP. This element is therefore <i>N/A</i>.</p> <p>Recommendation: HSAG recommends the DBA consult with the DHCFP to determine the process for disenrolling members should a disenrollment request be received. HSAG further recommends that the plan develop procedures to align with the process outlined by the DHCFP from those discussions.</p>		
	Required Actions: None.		
42 CFR §438.56(b)(2)	<p>3. Reasons a DBA May Not Request Disenrollment</p> <p>The DBA may not request disenrollment of a member for any of the following reasons:</p> <ul style="list-style-type: none"> a) An adverse change in the member’s health status; b) The member’s utilization of medical services; c) Diminished mental capacity; d) Uncooperative or disruptive behavior resulting from his or her special needs. 	<p>Documents Submitted:</p> <p>5. QM PP - Disenrollment Process</p> <p>Description of Process:</p> <p>See attachment: 5. QM PP - Disenrollment Process</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> N/A
	<p>Findings: The DBA’s contract with the DHCFP did not specify the reasons the DBA can request disenrollment of a member, nor did the contract indicate that the DBA may not request disenrollment of a member because of an adverse change in the member’s health status, or because of the member’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. Per the approved Member Handbook, enrollment and disenrollment questions were directed to the Nevada Medicaid District Office. This element is therefore <i>N/A</i>.</p> <p>Recommendation: HSAG recommends that the Member Handbook be updated to include that a member will not be disenrolled from the DBA due to an adverse change in the member’s health status, the member’s utilization of dental services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.</p>		
	Required Actions: None.		



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Results for Standard XIV: Enrollment and Disenrollment					
Total Elements	Met	= 1	X	1.00	= 1.00
	Partially Met	= 0	X	.50	= .00
	Not Met	= 0	X	.00	= .00
	Not Applicable	= 2	X	.00	= .00
	Total Applicable	= 1		Total Rate	= 1.00
Total Rate ÷ Total Applicable = Total Score					100%



Appendix B. Division of Health Care Financing and Policy
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2020 Corrective Action Plan Compliance Review Tool
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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) 2018–19 CAP Compliance Review

Standard VIII: Continuity and Coordination of Care			
Reference	Requirement	Information Submitted as Evidence by the DBA^{B-1}	Score
42 CFR §438.208(b)(2-4) 45 CFR Parts 160 and 164 42 CFR §438.208(b)(1) 42 CFR §438.224 DHCFP Contract Section 3.3.6.10 (A-B)	1. Coordination with Other vendors and Other Services Pursuant to 42 CFR §438.208(b) (2), (3), and (4) the DBA is required to implement procedures to coordinate services it may provide to the recipient with the services the recipient may receive from any other DBA. <ul style="list-style-type: none"> a. Upon request or notification of need, the DBA is required to communicate with other vendors serving the recipient the results of its identification and assessment of any special health care needs to ensure that services are not duplicated, and to ensure continuity of care. The DBA’s procedures must ensure that, in the process of coordinating care, each recipient’s privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 [(the Health Insurance Portability and Accountability Act (HIPAA))]. 	Documents Submitted: Description of Process:	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

^{B-1} The Information Submitted as Evidence by the DBA column was completed by the DBA and has not been altered by HSAG except for minor formatting.



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2020 Corrective Action Plan Compliance Review Tool
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Standard VIII: Continuity and Coordination of Care			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{B-1}	Score
	<ul style="list-style-type: none"> b. The DBA case managers are responsible for coordinating services with other appropriate Nevada Medicaid and non-Medicaid programs. c. In addition, the DBA is responsible for ensuring continuity of services for recipients with special needs. These recipients may include but are not limited to: 3.3.1.11 d. juveniles temporarily detained by a state or county agency; Seriously Emotionally Disturbed children, adults with Severe Mental Illness and individuals with substance abuse disorders; Children with Special Health Care Needs; homeless recipients; recipients with chronic conditions; women with pregnancies, and referring orthodontic recipients to their appropriate Dental Home for periodic examinations and cleanings. 		
<p>Findings: The policy, QM PP – Coordination of Dental Services, described LIBERTY’s policy to coordinate dental healthcare services to meet an individual’s specific needs to ensure timely coordination of services between the member, the plan, providers, as well as medical service providers. The policy also defined “special needs members” as those with physical and/or mental disabilities in need of dental care from providers who have special experience working with this population. The policy also described the methods to coordinate with pediatric specialists, sub-specialists, ancillary therapists, community resources, primary care dentists, and providers of specialized equipment and supplies for persons with special health care needs (SHCN). The policy, Continuity of Care System, described the process for outreaching to noncontracted providers to join LIBERTY’s network. LIBERTY staff members described the use of the Guardian network to support special needs of recipients when an in-network provider was not available. Neither policy described the care coordination and continuity of services for homeless or pregnant recipients.</p>			



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for LIBERTY Dental Plan of Nevada, Inc.



Standard VIII: Continuity and Coordination of Care			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{B-1}	Score
	<p>Recommendations: The DBA is responsible for ensuring continuity of services for recipients with special needs. These recipients may include homeless and pregnant recipients.</p>		
<p>Corrective Action Plan (Include required action, responsible individual, and completion date.)</p>	<p>Responsible Individual: Melinda Fife – Director, Member Services Completion Date: 12/5/2019 Required Action: CL PP - Continuity of Care System - NEVADA MEDICAID MSR PP - Access To Care Guidelines MSR PP - Out of Network Approval Process</p>		
<p>DHCFP Response (To be completed by DHCFP/HSAG.)</p>	<p>The CAP and the CL PP – Continuity of Care System – Nevada Medicaid, MSR PP – Access to are Guidelines, and MSR PP – Out of Network Approval Process policies and procedures did not specify how care coordination and continuity of services for recipients with special needs, such as homeless and pregnant recipients is accomplished. The CAP did not identify the required actions LIBERTY will take to remedy the deficiency identified for this element.</p> <p>The DHCFP rejects this CAP and requires LIBERTY to resubmit a CAP for this element that specifies how LIBERTY provides care coordination and continuity of services for recipients with special needs, such as homeless and pregnant recipients.</p>		
<p>LIBERTY’s Response</p>	<p>LIBERTY Dental makes a ‘best effort’ attempt to follow-up on members with compromised medical conditions. When applicable, a Member’s health plan is notified upon discovery of a potential medical high risk that will require coordination of benefits. LIBERTY’s Coordination of Dental Services system shall identify and eliminate any barriers to maintaining quality dental health care while monitoring program effectiveness. This process shall be based on dental diagnosis and determination of patient need. Please see attached 1. MSR SOP - Coordination of Care for Complex and Special Needs Cases (004).</p>		
<p>DHCFP Response (To be completed by DHCFP/HSAG.)</p>	<p>The MSR SOP – Coordination of Care for Complex and Special Needs Cases procedure outlined the processes for care coordination and continuity of services for recipients with special needs, including homeless and pregnant women.</p> <p>The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.</p>		



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Standard VIII: Continuity and Coordination of Care			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{B-1}	Score
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: LIBERTY has not experienced any cases pertaining to complex or special needs since the implementation of the CAP. LIBERTY is submitting the SOP that provides details for how coordination of care for complex care and special needs will be handled when a case is received. See attached:</p> <p>01. SOP CM MSR Nevada Medicaid Care Coordination Referral Process</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard VIII: Continuity and Coordination of Care			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
<i>DHCFP Contract Section 3.9.8.3 (D)</i>	4. Identification of Race and Ethnicity The DBA works collaboratively with DHCFP to determine recipient race and ethnicity. The DBA organizes interventions specifically designed to reduce or eliminate disparities in health care.	Documents Submitted: 04. CU PP - Membership Demographic Profile Description of Process: Please see description in the above P&P.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The policy, 04. CU PP – Membership Demographic Profile, described the process LIBERTY used to collect and analyze enrollee population demographic data to ensure the linguistic and cultural needs of enrollees are met and to reduce health disparities and achieve health equity. The meeting minutes from the Quarter 4 2018 Cultural and Linguistic Competency Committee meeting provided evidence that the committee reviewed member race and ethnicity reporting information as part of the meeting. Most of the information reported focused on the linguistic needs of the population served and the linguistic services provided by the dental provider. The reports, however, did not contain information about disparities that may exist in the services provided or accessed by the population. For example, the reports did not show how LIBERTY examined disparities through analysis of performance measures or PIP data to determine if certain ethnicities or races have disproportionate utilization of services and if so, what LIBERTY will do to reduce and eliminate those disparities.		
	Recommendations: LIBERTY must define the ways in which it uses data to identify healthcare disparities and organize interventions specifically designed to reduce or eliminate disparities in healthcare.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Crystal Tran – Cultural and Linguistics Competency Coordinator Completion Date: 12/17/2019 Required Action: LIBERTY Dental Plan reviews utilization data to identify health disparities and implement educational materials to both members and providers to reduce and eliminate disparities in healthcare. For example, on a quarterly basis, LIBERTY’s Dental Care Management Department reviews claims utilization data to track and trend the utilization of sealant services in children. When a disproportionate utilization in sealants is identified, educational materials are sent to the selected providers on the importance of utilizing sealants to reduce caries and other future oral health problems. See sample report in the attached HSAG CAP Response_12.17.19 and sample provider education letter Sealant Utilization Letter - Letterhead 2019.09.11 . The utilization report by procedure codes is a comparison between the number of fillings completed versus sealants.		



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DHCFP Response (To be completed by DHCFP/HSAG.)	While the NV Medicaid Procedure Code Utilization report and the Sealant Utilization letter template provided an example of how LIBERTY uses data to identify potential over and under utilization of services and an intervention designed to impact the level of services being provided by the dental providers, the report did not identify disparities according to race and ethnicity. Further, the intervention did not specify how the designed intervention would specifically reduce or eliminate the healthcare disparity of certain ethnicities or races. The DHCFP rejects this CAP and requires LIBERTY to resubmit a CAP that specifies how data is used to identify healthcare disparities and organize interventions specifically designed to reduce or eliminate disparities in healthcare.		
LIBERTY's Response	LIBERTY Dental Plan has an established process for identifying health disparities for targeted populations. Please see attached 4. Standard Operation Procedure – Identifying Health Disparities and Interventions.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The CU SOP – Identifying Health Disparities and Interventions procedure described the process for reviewing data routinely to identify health disparities according to race and ethnicity and implement interventions to improve dental health and reduce health disparities. LIBERTY's Cultural and Linguistic Competency (CLC) Committee reviews and analyzes the data at least quarterly to identify health disparities and develop interventions to the targeted populations. Any interventions developed will be reported to LIBERTY's Quality Management and Improvement Committee for further action. The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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</i></p> <p>LIBERTY's CLC Committee conducts quarterly reviews of data to identify health disparities and propose interventions. Attached is a slide from the Q1 2020 Cultural and Linguistic Competency Committee Deck, that assesses enrollee health disparities and further actions the committee recommends.</p> <p>VIII.04 - Q1 2020 Cultural and Linguistic Competency Committee Deck_Oral Health Disparities</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard IX: Grievances and Appeals			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §431.200(b) 42 CFR §431.220(6) 42 CFR §438.402(b) 42 CFR §438.10(g)(1) 42 CFR §438.10(2)(xi)(D) DHCFP Contract Section 3.12.6.2	1. Notification of State Fair Hearing Rights The DBA is required to inform the recipient of their right to a State Fair Hearing, how to obtain such a hearing, and representation rules must be explained and provided in writing to the recipient by the DBA.	Documents Submitted: 01. Notice of Action Your Rights Under Dental Managed Care 02. NV Medicaid Member Handbook 03. NV Medicaid Provider Reference Guide 04. NV Medicaid State Fair Hearing Form Description of Process: Members have the right to a State Fair Hearing once they have exhausted the Plan’s appeals system LIBERTY’s Member Handbook and website provides information to members of their right to State Fair Hearings. This information is also available with every adverse decision on the applicable “Your Rights” documents. LIBERTY has submitted the NV Medicaid Member Handbook and the Provider Reference Guide to DHCFP for review and will make any appropriate changes as required. Information on State Fair Hearing starts on page 36 of the Member Handbook and pg. 64 of the Nevada Medicaid Provider Reference Guide.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The document, Your Rights Under Dental Managed Care, provided evidence of LIBERTY’s notice to members about their right to a State fair hearing (SFH), how to obtain a hearing, and who may represent them at the hearing; however, the time frame for requesting a SFH was inconsistent with federal regulations. The sample NV Medicaid State Fair Hearing form submitted with the desk review documentation is titled Request for Hearing Before Appeals Officer. This is not the			



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	<p>correct State Fair Hearing Request form. The Nevada Medicaid Dental Program Member Handbook and the Nevada Medicaid Provider Resource Guide included information on the member’s right to a SFH, how to obtain such a hearing, and the rules for representation. LIBERTY staff members confirmed that the Your Rights Under Dental Managed Care document is provided to members with the NABD letter when a decision is made to deny, reduce, terminate, or suspend a service. The appeal file reviews demonstrated that the Your Rights Under Dental Managed Care documents were sent to members with the NABD; however, the files reviewed contained three different versions of the Your Rights Under Dental Managed Care document, where all but one version had incorrect time frames for filing appeals and requesting a SFH. During the on-site interview session, LIBERTY staff members stated they were aware of the incorrect time frame to request a SFH listed in the Your Rights Under Dental Managed Care document and had recently received approval from the DHC FP for the revised Your Rights Under Dental Managed Care document and request for a SFH.</p> <p>Recommendations: The DBA must ensure that the notice provided to members about SFH requests contains accurate, complete information that is consistent with federal regulations and provide members with the correct SFH request form.</p>		
<p>Corrective Action Plan (Include required action, responsible individual, and completion date.)</p>	<p>10/19 – Immediately upon notification from the DHC FP, the Plan implemented the appropriate Nevada Medicaid State Fair Hearing Form and the updated “Your Rights Under Dental Managed Care form for the NABD and NPAR letters followed by updating the Member Handbook and Provider Resource Guide. The following documents are currently in use and are provided as supporting documentation:</p> <ul style="list-style-type: none"> • NV Medicaid Fair Hearing Request Form • NV Medicaid NAR Your Rights • NV Medicaid NOA Your Rights • NV Medicaid Handbook 2020 DRAFT 		
<p>DHC FP Response (To be completed by DHC FP/HSAG.)</p>	<p>The Your Rights Under Dental Managed Care forms contained the required information that is consistent with federal regulations. The revised NV Medicaid Fair Hearing Request Form included in this CAP, on LIBERTY’s website and in the DRAFT 2020 NV Medicaid Handbook is the correct State Fair Hearing Request form. Recommend LIBERTY ensure the revised member handbook is finalized, approved by DHC FP, and distributed to members timely.</p> <p>The DHC FP accepts this CAP with recommendations.</p>		



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2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>LIBERTY implemented the updated State Fair Hearing form to the Grievance and Appeals staff as of August 28, 2019. LIBERTY received DHCFP approval for the 2020 NV Medicaid Handbook on February 10, 2020.</p> <p>IX. 01a - NV DHCFP Notice of Approval – Handbook IX. 01b – NV Medicaid Member Handbook 2020 (see page 51) IX. 01c – Staff Notification NV Medicaid State Fair Hearing Forms</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.402(a) DHCFP Contract Section 3.9.16.5 (A–F)	3. Recipient Grievance and Appeals Procedures This grievance and appeals system must include: <ul style="list-style-type: none"> a. Procedures for registering and responding to grievances and appeals within thirty (30) calendar days. DBAs establish and monitor standards for timeliness; b. Documentation of the substance of grievances, appeals, and actions taken; c. Procedures ensuring a resolution of the grievance and providing the recipient access to the State Fair Hearing process for appeals; d. Aggregation and analysis of grievance and appeal data and use of the data for quality improvement; e. Compliance with DHCFP due process and fair hearing policies and procedures specific to NV Medicaid and NV Check Up recipients; and f. Compliance with 42 CFR §438 Subpart F Grievance and Appeals. 	Documents Submitted: 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 03. Member Grievance and Appeal Form – NEVADA 04. Grievance and Appeals Process Flowchart 05. NV_Medicaid_Handbook 06. NV Medicaid Provider Reference Guide Description of Process: LIBERTY resolves all Medicaid member grievances and appeals within 30 calendar days of receipt, and expedited grievances and appeals are resolved within 72 hours from time of receipt. The Assistant Manager, QM, oversees the receipt and processing of all member grievances and appeals to ensure that each case is resolved in a timely manner. Additionally, weekly grievance and appeals reports are reviewed by the Supervisor of Grievance and Appeals to ensure timeliness.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
		Information on can be located on: GA PP – Grievance and Appeals Process – Medicaid -Appendix 2 Page 33 Nevada Medicaid Member Handbook Page 60 Nevada Medicaid Provider Reference Guide	
<p> Findings: While the GA PP—Grievance and Appeals Process (Medicaid) policy provided evidence of LIBERTY’s procedures for processing grievances and appeals, the language in the policy was inconsistent with federal regulations. The processes for handling member grievances and appeals used the terms “grievance” and “appeal” interchangeably, even though a grievance and appeal are distinctly different. Further, the policy described the process for “a second-level grievance involving an appeal of LIBERTY’s initial grievance determination.” However, it was not clear through LIBERTY’s written documentation how LIBERTY was using the second level grievance process. This policy also described LIBERTY’s process for logging all grievances and appeals in Uniflow, the DBA’s single source database, including documenting the details of the grievance or appeal and ensuring grievances and appeals are resolved according to State and federal requirements. The GA PP–Grievance and Appeals Process (Medicaid) policy also identified how grievances and appeals were aggregated and analyzed in support of continuous quality improvement. The Nevada Medicaid Member Handbook included an incorrect link to the State Fair Hearing Request form on the DHCFP website. </p> <p> It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records to the DBA. It was unclear if encrypted and secure email would be used. While LIBERTY’s email system may be secure and its emails encrypted, these conditions may not be true for a dental provider. Since dental records contain protected health information (PHI), caution should be used when transmitting PHI to ensure that the DBA is not in violation of any federal or State laws regarding the protection and security of PHI. During LIBERTY’s Readiness Review completed in 2017, this issue was also noted. LIBERTY submitted a corrective action plan (CAP) which included revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email. During the on-site interview session, LIBERTY staff members were unable to explain why the original dental record request letter was still in use and the revised request letter was not implemented after the 2018 </p>			



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	<p>CAP was approved. An increased risk for a breach of PHI when transmitting dental records from unsecured emails remains a concern.</p> <p>Post-on-site review response provided by LIBERTY on September 26, 2019, specified that effective September 26, 2019, the Grievance and Appeal Nevada Medicaid records request template with the revised and 2018 CAP approved language was implemented for automation within LIBERTY’s management information system (MIS) workflow and provided a sample of the template letter. Additionally, LIBERTY identified that Nevada grievance and appeal cases will be reviewed to determine if records were received by email. Providers are to be contacted to verify that dental record submissions were secure no later than October 11, 2019.</p>		
	<p>Recommendations: The DBA must ensure that grievance and appeal policies and procedures include accurate information that is consistent with federal regulations and the contract with the DHCFP; that members have access to the correct State Fair Hearing Request form; and when a dental provider emails dental records, that mechanisms are in place to assure protection and security of the member’s PHI. Further, it is recommended that LIBERTY develop mechanisms to ensure that remediations identified in CAPs are implemented.</p>		
<p>Corrective Action Plan</p> <p>(Include required action, responsible individual, and completion date.)</p>	<ul style="list-style-type: none"> • The Plan will be creating standalone policies for grievances and appeals to ensure compliance and consistency with federal regulations and contractual agreements with DHCFP. The anticipated completion date is 01/31/20. • The State Fair Hearing Request form has been updated; supporting documentation provided in response to item #1. • The Plan has updated on dental records request templates along with the Plan’s website to include the appropriate language to ensure the providers are aware the dental records that include PHI are transmitted via secure email portal. Additionally, the Plan has implemented an internal process for all departments for EPHI tracking and trending by the Compliance Department. 		
<p>DHCFP Response</p> <p>(To be completed by DHCFP/HSAG.)</p>	<p>The revised NV Medicaid Fair Hearing Request Form included in this CAP under element 1 is the correct State Fair Hearing Request form. Plans of action addressed the deficiencies.</p> <p>The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.</p>		



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>IX.03a – NV DHCFP Notice of Approval - GA Policies IX.03b – ZIP DHCFP approved GA policies – NEVADA MEDICAID – APPROVED 06.12.20 IX.03c – Staff Notification: NV Medicaid Policies Approval IX.03d -NV Medicaid Record Request-Screen Shot_Redacted IX.03e – LIBERTY Secure email portal webpage</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR Subpart F 42 CFR §438.402 42 CFR §438.414 DHCFP Contract Section 3.12.1	4. System to Resolve Grievances and Appeals The DBA shall establish: <ul style="list-style-type: none"> a. A system for recipients, which includes a grievance process, an appeal process, and access to the State Fair Hearing system. b. A similar system to resolve disputes with providers. 	Documents Submitted: 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Member Grievance and Appeal Form - NEVADA - APPENDIX 1 03. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2 04. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid 05. GA PP - Provider Complaint and Dispute Resolution Process - Medicare and Medicaid - APPENDIX 1 Description of Process: LIBERTY’s Grievance and Appeals Process ensures timely receipt, acknowledgement and resolution of all member grievances, appeals and State Fair Hearing requests. LIBERTY’s established Grievance and Appeals Process ensures timely receipt, acknowledgement and resolution of provider grievances, appeals and State Hearing requests.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy outlined the DBA’s procedures for processing grievances and appeals and providing access to the SFH system. The policy also outlined the process to resolve disputes with providers. The policy, however, did not use the correct terminology when referencing grievances or standard or expedited appeals. Specifically, the policy referenced expedited grievances and a second-level grievance involving an appeal of the		



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	<p>plan’s initial grievance determination, neither of which are consistent with federal regulations. Please refer to Element 1 of this standard for additional findings and recommendations.</p> <p>Recommendations: LIBERTY must ensure that policies describing the grievance and appeal processes include the correct terminology and that processes are consistent with federal regulations.</p>		
<p>Corrective Action Plan</p> <p>(Include required action, responsible individual, and completion date.)</p>	<p>The Plan will be creating standalone policies for expedited appeals and the SFH system to ensure compliance and consistency with federal regulations and contractual agreements with DHCFP. The anticipated completion date is 01/31/20.</p>		
<p>DHCFP Response</p> <p>(To be completed by DHCFP/HSAG.)</p>	<p>Plans of action addressed the deficiencies.</p> <p>The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.</p>		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>The Nevada Medicaid policies and procedures were approved was disseminated to the staff.</p> <p>See attachments submitted with Section IX, requirement 03.</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.414 42 CFR §438.10(g)(xi) DHCFP Contract Section 3.12.1.3	<p>5. Informing Enrollees and Providers about the Grievance System</p> <p>The DBA must provide information about the recipient and provider grievance system to recipients at the time of enrollment and to providers and subcontractors at the time they enter into a contract.</p>	<p>Documents Submitted:</p> 01. NV_Medicaid_Handbook 02. NV Medicaid Provider Reference Guide 03. Notice of Action Your Rights	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
		<p>Description of Process:</p> LIBERTY has an established Grievance and Appeals Process that both members and providers can access through multiple venues, including the Member Handbook, the Provider Reference Guide and on the Plan’s website. Information is also included with every notification of an adverse determination. <p>Page 33 of the Member Handbook Page 60 of the Nevada Medicaid Provider Reference Guide</p>	
<p>Findings: LIBERTY staff members stated during the on-site interview session that members receive a member handbook at the time of enrollment into the DBA. The NV-Medicaid-Handbook contained information about the member grievance system; however, the member handbook incorrectly informed members that if LIBERTY’s decision for a grievance is unsatisfactory to the member, a SFH can be requested. According to federal regulations, a SFH can only be requested for appeal decisions. The NV-Medicaid Provider Reference Guide provided evidence that the DBA included information about the recipient and provider grievance system in the Provider Manual.</p>			
<p>Recommendations: The DBA must ensure that the information included in the member handbook is accurate, complete, and consistent with federal regulations.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Corrective Action Plan (Include required action, responsible individual, and completion date.)	The Member Handbook has been updated; supporting documentation provided in response to item #1. The Nevada Medicaid Handbook has been updated. A copy of the draft version has been provided as supporting documentation.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>The Nevada Medicaid Handbook was approved and disseminated to the staff.</p> <p>Evidence submitted with Section IX, requirement 01.</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.402(c)(3)(i-ii) DHCFP Contract Section 3.12.2.7	<p>10. Grievances and Appeals Accepted Orally or in Writing</p> <p>A recipient, or a provider acting on behalf of the recipient, may file an appeal or grievance either orally or in writing.</p> <ul style="list-style-type: none"> a. Unless the recipient has requested an expedited resolution, an oral appeal must be followed by a written, signed appeal. b. If a grievance or appeal is filed orally, the DBA is required to document the contact for tracking purposes and to establish the earliest date of receipt. c. There is no requirement to track routine telephone inquiries. 	<p>Documents Submitted:</p> <ul style="list-style-type: none"> 01. GA PP - Grievance and Appeals Process – Medicaid 02. GA PP - Member Grievance and Appeal Form - NEVADA - APPENDIX 1 03. NV_Medicaid_Handbook 04. NV Medicaid Provider Reference Guide <p>Description of Process:</p> <p>LIBERTY accepts grievance and appeals in writing, orally or in person from enrollees or authorized representatives acting on behalf of enrollees.</p> <p>LIBERTY notifies enrollees that oral appeals must be followed-up with a written signed appeal. LIBERTY does not dismiss the enrollee appeal based solely on the fact the written appeal was not received following the oral submission for an appeal.</p> <p>Information located:</p> <ul style="list-style-type: none"> Pages 3-4 GA PP – Grievance and Appeals Process – Medicaid Pages 7-8 GA PP – Grievance and Appeals Process – Medicaid Pages 33-35 NV Medicaid Member Handbook 	<ul style="list-style-type: none"> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
		Page 61 NV Medicaid Provider Reference Guide	
<p>Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), detailed the processes for accepting grievances and appeals either orally or in writing. The policy described the process for documenting oral receipt of grievances and appeals to establish the earliest date of receipt for tracking purposes. For appeals filed by a provider on behalf of a recipient, the policy provided that the appeal may be followed by a written, signed appeal from the recipient. The Your Rights Under Dental Managed Care document that is included with the NABD and acknowledgement letters included the statement that for oral appeals, the member must complete and sign the appeal form and return it within 15 calendar days. If the member did not return the form, LIBERTY would not process the appeal. This practice is not consistent with the intent of the federal regulations that an oral appeal should be processed as a standard appeal even if the member does not follow the oral appeal with a written, signed appeal. Although the Your Rights Under Dental Managed Care document indicated that an oral appeal would not be processed unless a written, signed appeal was received, the appeal file reviews demonstrated that oral appeals were processed as standard appeals even when a written, signed appeal was not submitted by the member. The information included in policy and the Your Rights Under Dental Managed Care document were not consistent. During the on-site interview session, LIBERTY staff members acknowledged that the grievance and appeal template letters and Your Rights Under Dental Managed Care documents contained incorrect information and time frames. The staff members further stated that grievance and appeal template letters and the Your Rights Under Dental Managed Care document were revised and approved by the DHCFP on September 10, 2019, just prior to LIBERTY’s compliance review. According to LIBERTY staff members, the revised grievance and appeal template letters and Your Rights Under Dental Managed Care document were in the process of being updated in LIBERTY’s grievance and appeal electronic data system with implementation scheduled for the end of September 2019.</p>			
<p>Recommendations: The DBA must ensure that grievance and appeal template letters and the Your Rights Under Dental Managed Care document include all the requirements identified in federal regulations. Additionally, the DBA must ensure that information in policy and member information materials is consistent and meets federal regulations.</p>			



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Standard IX: Grievances and Appeals			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Corrective Action Plan (Include required action, responsible individual, and completion date.)	The Plan will be creating standalone policies for expedited appeals and the SFH system to ensure compliance and consistency with federal regulations and contractual agreements with DHCFP. The anticipated completion date is 01/31/20. The approved DHCFP templates were implemented prior to the compliance review; supporting documentation provided in response to item #1.		
DHCFP Response (To be completed by DHCFP/HSAG.)	Plans of action addressed the deficiencies. The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>LIBERTY received DHCFP approval of standalone Grievance and Appeal policies on June 12, 2020 and has promptly disseminated policies to the staff. Full implementation with staff acknowledgement is expected by June 15, 2020.</p> <p>See attachments submitted for Section IX Requirement 03.</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard IX: Grievances and Appeals			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.10(c-d) 42 CFR §438.404(a) DHCFP Contract Section 3.12.4.2 (A-C)	16. Language and Format of Written Notice of Action The notice must meet all of the following requirements: <ul style="list-style-type: none"> a. Be available in the State-established prevalent non-English languages; b. Be available in alternative formats for persons with special needs (visually impaired recipients, or recipients with limited reading proficiency); and c. Use easily understood language and format requirements of 42 CFR §438.404(c); 42 CFR §438.10(c) and (d). 	Documents Submitted: 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template Description of Process: LIBERTY ensures that all written Notice of Actions are issued within the cultural and linguistic needs of the NV Medicaid population. Information located: Page 3 UM PP - Coverage and Authorization of Services	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The UM PP–Coverage and Authorization of Services policy included information about the requirements of the notice, which were consistent with the requirements of this element. The file reviews revealed that five NABD letters contained language that was not easily understood and had typographical errors, grammatical errors, or an incorrect spelling of the member’s name.		
	Recommendations: The DBA must ensure that a notice contains easily understood language and format requirements as outlined in 42 CFR §438.404(c) and 42 CFR §438.10(c) and (d).		



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Corrective Action Plan (Include required action, responsible individual, and completion date.)	<p>In order to ensure that NABD letters are easily understood, with no or minimal typographical/grammatical errors and other avoidable user related errors, LIBERTY will create a coded matrix of pre-scripted language that includes clear and concise explanations of the reason for the decision based on the service and appropriate denial reasons, the matrix will include a pre-scripted description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and the clinical reasons for the decision regarding any medical necessity denials. Once the matrix is completed it will be sent for readability verification, grammatical and spelling checks; any necessary revisions to meet readability levels or other corrections will be performed before finalizing and implementing. If DHCFP is able and willing to take part in the final review of the language within the matrix, LIBERTY would be very interested in including them in the process or getting feedback before finalizing as well.</p> <p>The long term plan will be to integrate the matrix into the system so that the templates are auto populated based on the appropriate coding, which will further eliminate user errors with regard to grammatical, spelling or other typographical errors.</p>		
DHCFP Response (To be completed by DHCFP/HSAG.)		<p>This CAP response did not include an expected completion date nor the responsible individual.</p> <p>The DHCFP rejects this CAP and requires LIBERTY to provide the expected completion date and responsible individual for this CAP. Please forward the language in the coded matrix of pre-scripted language for the NABD letters once completed to DHCFP for review and feedback.</p>	
LIBERTY's Response		<ol style="list-style-type: none"> 1) Expected completion date: 03/31/2020 2) Responsible individual Kristina Rovirosa, V.P. Q.M. 3) A copy of the language will be provided to HSAG upon completion but no later than 03/31/2020. 	
DHCFP Response (To be completed by DHCFP/HSAG.)		<p>The revised CAP included an expected completion date and the responsible individual. Evidence of implementation will be assessed during the 2020 compliance review.</p> <p>The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.</p>	



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<p>DBA Evidence of Compliance: <i>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.</i></p> <p>Implementation of the revised appeal language matrix is an extensive project that was carved into several phases of implementation. Phase one began with establishing a workgroup and identifying the most utilized clinical denial rationales. The top utilized clinical rationales were then revised to be member centric and vetted for appropriate readability, grammatical and spelling accuracy. The revised language was implemented for phase one denial rationales and LIBERTY ensures the workgroup is convening on bi-monthly basis to review the continued oversight and revision of the remaining denial rationales.</p> <p>Phase two will include the review of the most utilized administrative denial rationales that will undergo the same level of review and scrutiny before implementing; this is estimated to be completed by Q3 2020.</p> <p>Phase three of the implementation plan will include additional cross walking of the revised matrix to hard code and automate into the current/approved Notice of Appeal Resolution (NPAR) templates and eliminate user typographical related errors; projected for completion by end of Q4 2020.</p> <p>IX.16 - Denial Rationale Matrix_Nevada Medicaid.</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.404(b)(1-6) 42 CFR §438.404(c)(1) 42 CFR §438.408(e)(1) 42 CFR §438.408(e)(2)(i-iii) 42 CFR §438.420(a)(i-ii) 42 CFR §438.420(b) DHCFP Contract Section 3.12.4.3(A-J), 3.12.4.4	<p>17. Requirements of a Written Notice of Action</p> <p>A written Notice of Action to the recipient must meet the following requirements and must explain:</p> <ul style="list-style-type: none"> a. The action the DBA or its subcontractor has taken or intends to take; b. The reasons for the action; c. The recipient's or the provider's right to file an appeal; d. The recipient's right to request a State Fair Hearing after the recipient has exhausted the DBA's internal appeal procedures; e. The procedures for exercising the recipient's rights to appeal; f. The circumstances under which expedited resolution is available and how to request it; g. The recipient's rights to have benefits continue if the appeal is filed on or before the latter of the following: within ten (10) calendar days of the DBA mailing the Notice of Action or the intended effective date or the proposed action pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which 	<p>Documents Submitted:</p> <ul style="list-style-type: none"> 01. UM PP - Coverage and Authorization of Services 02. NV-Medicaid EOB Template 03. NV-Medicaid UM Template <p>Description of Process:</p> <p>LIBERTY ensures that all written Notice of Actions include the federal and state regulatory language. Please reference attached exhibits</p> <p>Information located: Pages 3-5 UM PP - Coverage and Authorization of Services</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>the enrollee may be required to pay the costs of these services;</p> <p>h. That the recipient may represent himself or use legal counsel, a relative, a friend, or other spokesman;</p> <p>i. The specific regulations that support, or the change in federal or State law that requires the action;</p> <p>j. The recipient’s right to request an evidentiary hearing if one is available or a state agency hearing, or in cases of action based on change in law, the circumstances under which a hearing is granted; and,</p> <p>k. The DBA gives notice at least ten (10) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services. This timeframe may be shortened to five (5) days if probable recipient fraud has been verified.</p>		
<p>Findings: The UM PP–Coverage and Authorization of Services policy detailed the requirements of a notice of action, which included items a through k of this element. The file reviews verified that the notice of action included the requirement of this element; however, the Your Rights Under Dental Managed Care document attached to the written notice of action indicated that a member has 90 days from the date of the notice of action to file an appeal. The State and federal time frame to file an appeal is 60 days. LIBERTY staff members acknowledged that the Your Rights Under Dental Managed Care document contained incorrect information and time frames. The staff members further stated that grievance and appeal template letters and the Your Rights Under Dental Managed Care document were revised and approved by the DHCFP on September 10, 2019, just prior to LIBERTY’s compliance review. According to LIBERTY staff members, the revised grievance and appeal</p>			



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	template letters and Your Rights Under Dental Managed Care document were in the process of being updated in LIBERTY's grievance and appeal electronic data system, with implementation scheduled for the end of September 2019.		
	Recommendations: The DBA must ensure that written notice of action and supplemental information included with the written notice contain the correct time frames for filing an appeal or SFH identified in federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	The approved DHCFP templates were implemented prior to the compliance review; supporting documentation provided in response to item #1.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
DBA Evidence of Compliance: <i>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.</i>			
LIBERTY received approval from DHCFP for our remediation plan on March 15, 2020 and has since began implementation of the approved NOA sample. The template has been updated to comply with the federal update to "NABD" and is currently undergoing programing and testing and is expected to be in production as of June 30, 2020.			
IX.17a - NV Medicaid NABD Template 2020			
IX.17b - NV Medicaid NOA Your Rights – FINAL			
HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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42 CFR §438.404(c)(5-6) 42 CFR §438.408(b)(1-2) 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) DHCFP Contract Section 3.12.5 – 3.12.5.3	<p>20. Handling of Grievances and Appeals</p> <p>The DBA 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:</p> <ul style="list-style-type: none"> a. Standard disposition of grievances: The DBA is allowed no more than ninety (90) calendar days from the date of receipt of the grievance. b. Standard resolution of appeals: The DBA is allowed no more than thirty (30) calendar days from the date of receipt of the appeal. c. Expedited resolution of appeals: The DBA must resolve each expedited appeal and provide notice, as expeditiously as the recipient’s health condition requires, not to exceed seventy-two (72) hours after the DBA received the expedited appeal request. 	<p>Documents Submitted:</p> <p>01. GA PP – Grievance and Appeals Process – Medicaid</p> <p>02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2</p> <p>Description of Process:</p> <p>LIBERTY’s established grievance and appeals process ensure proper resolution within all federal and contractual turnaround times for standard and expedited cases.</p> <p>Information located:</p> <p>Page 6 GA PP – Grievance and Appeals Process – Medicaid</p> <p>Pages 10-11 GA PP – Grievance and Appeals Process – Medicaid</p> <p>Page 14-15 GA PP – Grievance and Appeals Process – Medicaid</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that although Nevada allows up to 90 days to resolve grievances, LIBERTY will resolve all grievances and appeals within 30 calendar days. For resolving expedited resolution of appeals, Appendix 2 of the policy included the provision that expedited appeals must be resolved within 72 hours of the receipt of the expedited appeal. The grievance file review confirmed that all 10 grievances were resolved within the required time frame. The appeal file review showed that two of the three expedited appeal files reviewed</p>			



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	<p>were resolved within the required 72 hours and that no notice of extension was sent for the one expedited appeal that was resolved outside the 72-hour time frame. All seven standard appeals reviewed were resolved within the 30-day time frame.</p> <p>Recommendations: The DBA must ensure that expedited appeals are resolved within the required time frames and that notice to affected parties is provided if an extension of the resolution time frame is requested.</p>		
<p>Corrective Action Plan (Include required action, responsible individual, and completion date.)</p>	<p>10/04/19 – Training was completed with the grievance and appeals staff that included the expedited appeal process and resolution timeframes. A copy of the training and department sign in sheet are included as supporting documentation.</p>		
<p>DHCFP Response (To be completed by DHCFP/HSAG.)</p>	<p>The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.</p>		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>FL017275394 is a sample of an expedited appeal that was resolved within 72 hrs and the enrollee verbal notification was conducted timely.</p> <p>IX.20a - Expedited Appeal Universe IX.20b - Expedited Appeal Resolution_Verbal Notification</p> <p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met</p>



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.408(d)(2)(i) 42 CFR §438.410(a-b) 42 CFR §438.410(c)(1-2) DHCFP Contract Section 3.12.5.3, 3.12.5.3(A-B)	<p>21. Expedited Review Process for Appeals</p> <p>The DBA is required to establish and maintain an expedited review process for appeals when the DBA determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the recipient’s life or health or ability to attain, maintain, or regain maximum function.</p> <ul style="list-style-type: none"> a. The DBA must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an appeal. b. If the DBA denies a request for an expedited resolution of an appeal, it must transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the DBA receives the appeal (with a possible fourteen (14) calendar day extension) for resolution of appeal and give the recipient prompt oral notice of the denial and follow up within two (2) calendar days with a written notice. c. The DBA must inform the recipient of the limited time available to present evidence and allegations of fact or law, in person or in writing, in the case of the expedited resolution. d. These time frames may be extended up to 14 calendar days if the recipient requests such an extension or the DBA demonstrates to the 	<p>Documents Submitted:</p> <p>01. GA PP - Grievance and Appeals Process – Medicaid</p> <p>02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2</p> <p>Description of Process:</p> <p>LIBERTY’s established grievances and appeals process accounts for circumstances in which a standard resolution could seriously jeopardize the enrollee’s life or health requiring expedited resolution.</p> <p>Information located:</p> <p>Page 14-16 GA PP – Grievance and Appeals Process – Medicaid</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>satisfaction of the DHCFP that there is a need for additional information and how the extension is in the recipient’s interests.</p> <p>e. If the State grants the DBA’s request for an extension, the DBA gives the recipient written notice of the reason for the delay.</p>		
	<p>Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy described LIBERTY’s processing of expedited appeals which included all requirements of this element. While the policy identified that prompt oral notice be provided to a member when the DBA denies a request for an expedited appeal resolution, one of the 10 appeal files reviewed did not contain documentation that prompt oral notice of a decision to deny the member’s request for an expedited appeal was provided to the member or member’s representative.</p>		
	<p>Recommendations: The DBA must ensure that members receive prompt oral notice of the denial of a request for an expedited appeal resolution.</p>		
<p>Corrective Action Plan (Include required action, responsible individual, and completion date.)</p>	<p>10/04/19 – Training was completed with the grievance and appeals staff that included the expedited appeal process and resolution timeframes; supporting documentation provided in response to item #20.</p>		
<p>DHCFP Response (To be completed by DHCFP/HSAG.)</p>	<p>The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.</p>		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
		FL017275394 is a sample of an expedited appeal that was resolved within 72 hrs and the enrollee verbal notification was conducted timely.	
	Section IX, Requirement 20.		
HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.10(g)(2)(xi) 42 CFR §438.406(a) 42 CFR §438.406(b)(1-2(i-ii)) DHCFP Contract Section 3.12.5.4(A-D)(1-3)	<p>22. Notification of Disposition of Grievances and Appeals</p> <p>In handling grievances and appeals, the DBA meets the following requirements:</p> <ul style="list-style-type: none"> a. The DBA must provide recipients any reasonable assistance in completing forms and taking other procedural steps, including assisting the recipient and/or the recipient’s representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing. This also includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability; b. Acknowledge receipt of each grievance and appeal; c. Ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making; and d. Ensure that the individuals who make decisions on grievances and appeals are health care professionals who have the appropriate clinical expertise, in treating the recipient’s condition or disease if the 	<p>Documents Submitted:</p> <p>01. GA PP - Grievance and Appeals Process – Medicaid</p> <p>02. GA PP - Grievance and Appeals Process - Medicaid - APPENDIX 2</p> <p>Description of Process:</p> <p>LIBERTY’s Member Services Department is trained to not only appropriately respond to inquiries from members, but also offer the grievance and appeals process when found to be appropriate. This includes offering assistance completing the form, explaining the website grievance and appeals submission process and educating the member on language assistance and/or arranging non-emergency transportation, as needed.</p> <p>LIBERTY’s established grievance and appeals process ensures written enrollee acknowledgement and disposition letters</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	grievance or appeal involves any of the following: <ol style="list-style-type: none"> i. An appeal of a denial that is based on medical necessity; ii. A grievance regarding the denial of an expedited resolution of an appeal; or iii. A grievance or appeal that involves clinical issues. 	within all federal and state regulatory turnaround times. Information located: Pages 3-10 GA PP – Grievance and Appeals Process – Medicaid	
<p>Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy addressed LIBERTY’s plan for processing and resolving grievances and appeals for requirements a through d of this element. The policy contained the provisions that individuals who made decisions on grievances and appeals were healthcare professionals who had the appropriate clinical expertise if the grievance or appeal involved an appeal of a denial that is based on medical necessity, a grievance regarding the denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues. Three of the 10 appeal files reviewed did not demonstrate that members were provided with grievance rights when LIBERTY made the decision to deny the member’s expedited appeal request. The GA PP–Grievance and Appeals Process (Medicaid) policy identified that LIBERTY would acknowledge receipt of grievances and appeals within five calendar days of receipt. The review of grievance and appeal files confirmed that all acknowledgement letters were provided to the member or member’s representative within five calendar days of receipt of the grievance or appeal. All 10 appeal files reviewed contained evidence that individuals who made decisions on the grievance or appeal were not involved in any previous level of review or decision making. All 10 appeal and 10 grievance files reviewed contained documentation which verified that licensed dentists rendered the appeal or grievance decision.</p>			
<p>Recommendations: The DBA must ensure that when an expedited appeal request is denied by LIBERTY, the member or member’s representative is provided with grievance rights.</p>			



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Corrective Action Plan (Include required action, responsible individual, and completion date.)	The approved DHCFP templates were implemented prior to the compliance review. A copy of the NV Medicaid Appeal Downgrade Acknowledgement template is included as supporting documentation.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>FL017306218 is a sample of the approved expedited appeal downgrade template that has been implemented, which includes the grievance rights.</p> <p>IX.22 - FL01306218 Expedited Appeal Downgrade Acknowledgement</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.406(b)(1-3) 42 CFR §438.406(b)(4-6) DHCFP Contract Section 3.12.5.5(A-D)	23. Process for Appeals The process for appeals also requires: <ul style="list-style-type: none"> a. That oral inquiries seeking to appeal an action are treated as appeals (in order to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the recipient requests expedited resolution; b. That the recipient is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and that the recipient is informed by the DBA of the limited time available for this in the case of expedited resolution; c. That the recipient and his/her representative are provided the opportunity, before and during the appeals process, to examine the recipient’s case file, including medical records, and any other document and records considered during the appeals process; and d. Include, as parties to the appeal, the recipient and his/her representative or the legal representative of a deceased recipient’s estate. 	Documents Submitted: 01. GA PP - Grievance and Appeals Process – Medicaid 02. Grievance and Appeals Process Flowchart Description of Process: LIBERTY’s appeals process is described throughout LIBERTY’s policy titled “Grievance and Appeals Process-Medicaid. Please reference the attached exhibit. Information located: Pages 7-8 GA PP – Grievance and Appeals Process – Medicaid Page 12 GA PP – Grievance and Appeals Process – Medicaid Page 14 GA PP – Grievance and Appeals Process – Medicaid	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The policy, GA PP–Grievance and Appeals Process (Medicaid), detailed the processes for accepting appeals either orally or in writing. The policy described the process for documenting oral receipt of appeals to establish the earliest date of receipt for tracking purposes. For appeals filed by a provider on behalf of a recipient, the policy provided that the appeal may be followed by a written, signed appeal from the recipient. The Your Rights Under Dental Managed Care document that is included with the NABD and acknowledgement letters included the statement that for oral appeals, the member must			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	complete and sign the appeal form and return it within 15 calendar days. If the member did not return the form, LIBERTY would not process the appeal. This practice is not consistent with the intent of the federal regulations that an oral appeal should be processed as a standard appeal even if the member does not follow the oral appeal with a written, signed appeal. Although the Your Rights Under Dental Managed Care document indicated that an oral appeal would not be processed unless a written, signed appeal was received, the appeal file reviews demonstrated that oral appeals were processed as standard appeals even when a written, signed appeal was not submitted by the member. The information included in policy and the Your Rights Under Dental Managed Care document were not consistent.		
	Recommendations: The DBA must ensure that information included in policy and member information materials is consistent and meets the federal regulations.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	The approved DHCFP templates were implemented prior to the compliance review. A copy of the NV Medicaid Member GA Form is included as supporting documentation. The Plan will be creating standalone policies for appeals to ensure compliance and consistency with federal regulations and contractual agreements with DHCFP. The anticipated completion date is 01/31/20.		
DHCFP Response (To be completed by DHCFP/HSAG.)	Plans of action addressed the deficiencies. The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
DBA Evidence of Compliance: <i>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.</i> LIBERTY received DHCFP approval of standalone Appeals policies on June 12, 2020 and has promptly disseminated policies to the staff. Full implementation with staff acknowledgement is expected by June 15, 2020. See attachments submitted for Section IX requirement 03.			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
IX.23 - NV Medicaid Web G_A Form			
HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Appendix B. Division of Health Care Financing and Policy
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for LIBERTY Dental Plan of Nevada, Inc.



Standard IX: Grievances and Appeals			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.408(e)(2)(iii) DHCFP Contract Section 3.12.5.6 (A-C)	<p>25. Notice for Written Appeals not Resolved in Favor of the Recipient</p> <p>For appeals that are not wholly resolved in favor of the recipient, the notice includes:</p> <ul style="list-style-type: none"> a. The right of the recipient to request a State Fair Hearing from the DHCFP and how to do so; b. The right to request to receive benefits while the hearing is pending and how to make this request; and, c. That the recipient may be held liable for the cost of those benefits if the State Fair Hearing’s Officer upholds the DBA’s action. 	<p>Documents Submitted:</p> <p>01. GA PP - Grievance and Appeals Process – Medicaid</p> <p>02. Notice of Action Your Rights</p> <p>Description of Process:</p> <p>The Your Rights Document provides enrollees with instructions on how to file an State Fair Hearing and that they may have to pay for the cost of any continued benefits if the final decision is not in their favor.</p> <p>Information located:</p> <p>Page 11 GA PP – Grievance and Appeals Process – Medicaid</p> <p>Page 17 GA PP – Grievance and Appeals Process – Medicaid</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that LIBERTY would notify the member of the right to request a SFH for appeals that are not wholly resolved in favor of the member. The document, Your Rights Under Dental Managed Care, contained information about the members’ right to request a SFH and how to obtain one; the right to request the continuation of benefits and how to do so; and that the member could be held liable for the costs of treatment if the final decision is not in the member’s favor. All appeal files reviewed contained written resolution notices and the Your Rights Under Dental Managed Care document; however, the notice for written appeals that are not wholly resolved in the member’s favor did not include the member’s right to request a SFH but provided the member with appeal rights.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	Recommendations: The DBA must ensure that the notice for written appeals that are not wholly resolved in the member’s favor include the member’s right to request a SFH from the DHCFP and how to do so.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	The approved DHCFP templates were implemented prior to the compliance review. A copy of the NV Medicaid Notice of Appeal Resolution Uphold template is included as supporting documentation.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA 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.</p> <p>LIBERTY implemented the approved DHCFP templates prior to Compliance Review. Notification to staff was sent on September 12, 2019. FL01708257 is a sample of a Notice of Appeal Resolution letter that supports the enrollee was provided with the State Fair Hearing language, Your Rights Document and Fair Hearing Form.</p> <p>IX.25a – Staff Notification – NV Medicaid Templates IX.25b – FL0170989257 – NV Medicaid NAR</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard IX: Grievances and Appeals			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.408 (d)(2)(ii) DHCFP Contract Section 3.12.5.7	26. Written Notice of Expedited Appeal Resolutions For expedited appeal resolution requests, the DBA makes a good faith effort to provide an oral notice of the disposition in addition to the required written notice.	<p>Documents Submitted:</p> <p>01. GA PP - Grievance and Appeals Process - Medicaid</p> <p>Description of Process:</p> <p>LIBERTY’s expedited appeals process ensures that members receive oral notification if their request for an expedited appeal resolution has been approved or denied.</p> <p>Information located:</p> <p>Page 7-8 GA PP – Grievance and Appeals Process – Medicaid</p> <p>Page 14 GA PP – Grievance and Appeals Process – Medicaid</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The GA PP–Grievance and Appeals Process (Medicaid) policy included the provision that LIBERTY would contact the member by telephone within 24 hours of the decision for expedited appeals in addition to providing the written notice of resolution. Documentation that LIBERTY made reasonable efforts to provide oral notice of resolution for an expedited appeal was demonstrated in two of the three expedited appeals reviewed.</p>			
<p>Recommendations: The DBA must ensure that reasonable efforts to provide oral notice of resolution for an expedited appeal are documented in the appeal file.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Corrective Action Plan (Include required action, responsible individual, and completion date.)	10/04/19 – Training was completed with the grievance and appeals staff that included reasonable efforts to provide oral notice of resolution for an expedited appeal to enrollees; supporting documentation provided in response to item #20.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>FL017275394 is a sample of an expedited appeal that was resolved within 72 hrs and the enrollee verbal notification was conducted timely.</p> <p>See attachments submitted for Section IX Requirement 20.</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Appendix B. Division of Health Care Financing and Policy
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Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.206(b)(4) DHCFP Contract Section 3.3.5	4. Out-of-Network Services If the DBA’s provider network is unable to provide medically necessary services covered under the plan to a particular recipient, the DBA must adequately and timely cover these services out-of-network for the recipient for as long as the DBA is unable to provide them.	Documents Submitted: UM PP - Coverage and Authorization of Services NM PP - Access and Availability Guidelines Description of Process: Please see description of process in the above P&P.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The UM PP–Access and Availability Guidelines policy addressed protocols to provide services from an out-of-network provider when access to in-network services are limited. While the policy did not identify that out-of-network services would be continued for as long as LIBERTY was unable to provide reasonable access to a contracted provider, staff members stated during the on-site interview that LIBERTY would provide services until such services are no longer necessary or the out-of-network provider becomes an in-network provider.		
	Recommendations: The DBA must ensure that if the DBA’s provider network is unable to provide medically necessary services covered under the plan to a particular member, the DBA must adequately and in a timely manner cover these services out-of-network for the recipient for as long as the DBA is unable to provide them.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Sydney Lee – Director, Quality Management Date of Completion: 12/4/2019 Action: 1. See attached policy; UM PP - Coverage and Authorization of Services. The policy includes an update under Coverage Services section #6. If the LIBERTY provider network is unable to provide medically necessary services covered under the plan to a particular member, LIBERTY will adequately and in a timely manner cover these services		



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	out-of-network for the recipient until such services are no longer necessary or the out-of-network provider becomes an in-network provider		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>LIBERTY implemented the attached form to process any OON requests any time an in-network provider is not available. Currently, the NV Medicaid network is sufficient, and we have not had to utilize the OON process.</p> <p>X.04 – OON Request Form</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
<p>Required Actions: None.</p>			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
<i>DHCFP Contract Section 3.5.5.1</i>	7. Personnel Completing the Children with Special Health Care Needs (CSHCN) Assessment The assessment of CSHCN is completed by appropriately qualified health care professionals.	Documents Submitted: QM PP - Coordination of Dental Services Description of Process: Please see description of process in the above P&P.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The QM PP–Coordination of Dental Services policy identified that LIBERTY would implement and maintain services for children with special health care needs (CSHCN) including a comprehensive oral assessment. While the policy included language about a comprehensive oral assessment for CSHCN members, it did not specify who is responsible for completing the assessment or how LIBERTY ensures individuals completing assessments are appropriately qualified professionals. During the on-site interview, LIBERTY staff members were unable to demonstrate an understanding of the requirements for this element as the staff members were not familiar with the process for CSHCN assessments.		
	Recommendations: The DBA must ensure that the assessment of CSHCN is completed by appropriately qualified professional and that staff are trained on the relevant policies and procedures.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Janet Musto – Director, Utilization and Case Management Completion Date: January 2020 Action: <ol style="list-style-type: none"> See attached new policy; QM PP - Coordination of Dental Services – NEVADA. The policy will include a Case Manager (LVN, Dental Hygienist, or Dental Assistant), who will work collaboratively with the Specialty Referral unit to ensure coordination with the Dental Provider and Medical Provider while ensuring completion of the CSHCN assessment form. The policy was updated to specifically mandate these requirements. Ensure training of case management personnel in understanding Special Care Needs population and the role of CSHCN assessment form in documenting those needs. Training to achieve these requirements will be implemented January 2020. 		



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Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
DHCFP Response (To be completed by DHCFP/HSAG.)	The QMPP – Coordination of Dental Services – Nevada policy referenced in this CAP was not provided and therefore not reviewed as part of this CAP. The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>The Case Management/Care Coordination assigned team at LIBERTY receives training upon assignment to this account and on an ongoing basis thereafter. LIBERTY has specifically developed Standard Operating Procedures for the NV Medicaid Program to allow for accuracy and consistency with our enrollees by each assigned team member.</p> <p>X.07a - SOP QM CM MSR Nevada Medicaid Care Coordination Referral Process X.07b - SOP QM CM Nevada Medicaid Care Coordination Process, X.07c - Documentation of training ZIP folder (calendar invites with sign in sheets) X.07d - Report for Nevada Medicaid GPNVN Case Management/Care Coordination 01.01.20 to 05.31.20 X.07e - Children with Special Health Care Needs (CSHCN) Form_ 1219</p> <p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.208 (c)(3-4) 42 CFR §438.208(c)(3)(i-ii) DHCFP Contract Section 3.5.5.1 (A-C)	8. Treatment Plans for CSHCN The DBA must produce a treatment plan for recipients with special health care needs (CHSCN) who are determined through an assessment to need a course of treatment or regular care monitoring. The treatment plan must be: <ol style="list-style-type: none"> Developed by the recipient’s primary dental provider with recipient participation, and in consultation with any specialists caring for the recipient; Approved by the DBA in a timely manner, if approval is required by the DBA; and, In accordance with any applicable State QA and utilization review standards. 	Documents Submitted: QM PP - Coordination of Dental Services Description of Process: Please see description of process in the above P&P.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The QM PP–Coordination of Dental Services policy specified that complex and special needs cases would be referred to a care coordinator who would work with the Specialty Referral unit to ensure coordination of dental services from a specific, agreed-on treatment plan between LIBERTY’s dental director, primary dental provider, and primary care medical provider, and the member’s guardian. The policy also confirmed that LIBERTY required CSHCN to have a written dental treatment plan. During the on-site interview, LIBERTY staff members were unable to demonstrate an understanding of the requirements for this element as the staff members were not familiar with the process for CSHCN treatment plans.			
Recommendations: The DBA must ensure that treatment plans for CSHCN are developed by the recipient’s primary dental provider with member participation and in consultation with any specialists caring for the recipient; and that they are approved by the DBA in a timely manner, if approval is required by the DBA, and in accordance with any applicable State quality assurance (QA) and utilization review standards.			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Janet Musto – Director, Utilization and Case Management Completion Date: 01/01/2020 Action:		
	1. The CSHCN treatment plan template will be created and implemented by LIBERTY Dental Plan. Draft plan template is currently under review and will be implemented by January 1, 2020. 2. Upon identification of children with Special Care Needs to LIBERTY Dental Case Management the attached draft Children with Special Health Care Needs (CSHCN) Form will be transmitted to the dental and/or medical provider for completion. LIBERTY requests HSAG/DHCFP for the review and any comments of the CSHCN Form prior to LIBERTY’s implementation.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The Children with Special Health Care Needs (CSHCN) Physician Assessment form requests information from the medical provider(s) that would provide the dental provider with comprehensive medical information to treat the member while taking into consideration the member’s special health care needs. The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>The CSCHN Assessment Form is completed by licensed physicians only for documentation of need for Children with Special Needs. The Case Management/Care Coordination team sends to Physician for completion and follow up to the servicing dental provider.</p> <p>X.08a - QM PP-Coordination of Dental Services-NEVADA, (see page 3) X.08b - CSHCN Assessment Form</p>			
<p>HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.114(c)(1)(i) 42 CFR §438.114(c)(3)(ii)(A and B) 42 CFR §438.114(d)(1)(i-ii) 42 CFR §438.114(d)(3) DHCFP Contract Section 3.3.6.1–3.3.6.5	<p>10. Emergency Dental Services</p> <p>The DBA may not deny payment for emergency services treatment when a representative of the DBA instructs the recipient to seek emergency services. The DBA shall be responsible for dental related services provided in an emergency.</p> <p>In providing for emergency dental services and care as a covered service, the DBA shall not:</p> <ol style="list-style-type: none"> Require prior authorization for emergency dental services and care Indicate that emergencies are covered only if care is secured within a certain period of time Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered. Deny payment based on the member’s failure to notify the DBA in advance or within a certain period of time after the care is given. Deny payment for emergency dental care unless it is performed under the medical benefit in a hospital, emergency room or ambulatory surgery center. Deny payment for treatment obtained when a member had an emergency dental condition and stabilization of condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 	<p>Documents Submitted:</p> <p>UM PP - Emergency Services Expedited Dental Services</p> <p>UM PP - Payment to Out of Network Provider</p> <p>Description of Process:</p> <p>Please see description of process in the above P&P.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	42 CFR §438.114(a) of the definition of an emergency dental condition.		
<p>Findings: The UM PP–Emergency Dental Services/Expedited Dental Services policy specified that LIBERTY would not deny payment for emergency services when a LIBERTY representative instructed a recipient to seek emergency care, or if emergency care was provided within a certain period of time, as required by this element. This policy identified LIBERTY’s responsibility to provide emergency dental services 24 hours a day, seven days a week at any in- or out-of-network provider. While this policy indicated that emergency services would not require prior determination of benefits, it did not specify that post-authorization was also not required. Additionally, this policy indicated that LIBERTY would not deny payment for treatment obtained when a recipient had an emergency dental condition but did not specify that payment would not be denied when the member required stabilization of a condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an “emergency dental condition.” This deficiency was also noted during LIBERTY’s Readiness Review, which required a CAP. LIBERTY submitted a revised Emergency Dental Services/Expedited Dental Services policy as part of its CAP that included the following language:</p> <p style="padding-left: 40px;">Emergency services do not require prior- nor post-authorization and are covered in cases where a prudent layperson, acting reasonably, would have believed that an emergency dental condition existed. Payment will not be denied solely on the determination that the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an “emergency dental condition.”</p> <p>LIBERTY’s revised policy and CAP were approved by the State, but LIBERTY did not implement the revised policy, which was confirmed by LIBERTY staff members during the on-site interview session.</p> <p>Recommendations: LIBERTY must ensure that it does not deny payment for treatment obtained when the recipient had an emergency dental condition and stabilization of condition, including cases in which the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an “emergency dental condition.” It is recommended that LIBERTY add to policy that post-authorization is also not required for emergency services. Further, it is recommended that LIBERTY develop mechanisms to assure that revised policies are implemented.</p>			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Sydney Lee – Director, Quality Management Completion Date: 12/03/2019 Action: Please see the attached policy UM PP - Emergency Services Expedited Dental Services , highlighted first paragraph of the ‘policy’ section; Emergency services do not require prior nor post-stabilization approval and are covered in cases where a prudent layperson, acting reasonably, would have believed that an emergency dental condition existed. Payment will not be denied solely on the determination that the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an “emergency dental condition”. Also attached policy, QM PP - Policy and Procedure Criteria Development , LIBERTY has updated the internal process for policy and procedure development for new and/or revised policies and the process to obtain formal approvals for implementation of the policies.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
DBA Evidence of Compliance: <i>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</i> Per LIBERTY’s policy emergency services do not require prior- nor post-authorization and are covered in cases where a prudent layperson, acting reasonably, would have believed that an emergency dental condition existed. Payment will not be denied solely on the determination that the absence of immediate dental attention would not have had the outcomes specified in 42 CFR §438.114(a) of the definition of an “emergency dental condition. Attached sample of Emergency Services Claim payment X.10 - Sample Approved Emergency Services			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.210(b)(2)(ii) 42 CFR §438.210(b)(3) DHCFP Contract Section 3.9.19.3 (A–D)	20. Pre-authorization Review Requirements For DBAs with pre-authorization review programs: <ul style="list-style-type: none"> a. Pre-authorization decisions must be supervised by qualified dental professionals; b. Efforts are made to obtain all necessary information, including pertinent clinical information, and consult with the treating dentist as necessary; c. The reasons for decisions are clearly documented and available to the recipient; d. The DBA’s prior authorization policies and procedures must be consistent with provision of covered medically necessary dental care in accordance with community standards of practice. 	Documents Submitted: UM PP - Review Criteria_Referral Review, Approve, Modify or Deny Description of Process: Please see description of process in the above P&P.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The QM PP–Appropriate Professionals policy specified that appropriately licensed healthcare professionals supervise all review decisions, that appropriately licensed professionals supervise all dental necessity denials of care, that only a licensed dentist may deny a request for dental services, and that board-certified/board-eligible specialists or academic specialists are consulted when applicable to make decisions based on dental necessity. The UM PP–Coverage and Authorization of Services, the QM PP–Coverage of EPSDT Services, and QM PP–Appropriate Professionals documents collectively outlined the procedures for authorizing dental services in accordance with dental necessity and standards of practice. The policies reviewed did not describe efforts made to obtain all necessary information, including pertinent clinical information; consultation with the treating dentist as necessary; nor did the policies cite reasons for decisions to be clearly documented and available to the member.			



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	Recommendations: The DBA must ensure that its UM program includes the description of efforts made to obtain all necessary information, including pertinent clinical information; consultation with the treating dentist as necessary before rendering an authorization decision; and that reasons for decisions be clearly documented and available to the member.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	Responsible Individual: Sydney Lee – Director, Quality Management Completion Date: 12/03/2019 Action: Please see the attached policy UM PP - Clinical Criteria for UM Decisions , highlighted line #10 with the above language included; 10. The licensed dentist will make their “best efforts” to obtain all necessary information, including pertinent clinical information, and consult with the treating dental provider as appropriate in making UM decisions. For prospective and concurrent reviews, only pertinent records shall be requested from treating providers (if not provided with the initial submission request). For prospective review, LIBERTY may request partial or complete records. LIBERTY will not routinely request or require providers to submit dental records for all patients.		
DHCFP Response (To be completed by DHCFP/HSAG.)	The DHCFP accepts this CAP. Evidence of implementation will be assessed during the 2020 compliance review.		
2020 CAP Compliance Review			
DBA Evidence of Compliance: LIBERTY will make their “best efforts” to obtain all necessary information, including pertinent clinical information, and consult with the treating dental provider as appropriate in making UM decisions. The attached log reflects the outreach attempts and the documents/evidence we requested. X.20 - DCO Report Data 07.01.2019_12.31.2019			
HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.210(b)(3) 42 CFR §438.406(b)(2)(ii) DHCFP Contract Section 3.3.1.3 (D)	<p>22. Clinical Expertise of Staff Denying Services</p> <p>Any decision made by the DBA to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a dental professional who has appropriate clinical expertise in treating the recipient's condition or disease.</p> <p><i>Cross- reference Denials File Review Tool.</i></p>	<p>Documents Submitted:</p> <p>UM PP - Clinical Criteria for UM Decisions</p> <p>QM PP - Appropriate Professionals</p> <p>Description of Process:</p> <p>Please see description of process in the above P&P.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The QM PP–Appropriate Professionals policy identified that LIBERTY required qualified healthcare professionals to make UM decisions on medical/dental necessity. This policy further specified that only a licensed dentist could deny a request for dental services based on dental necessity, and that board-certified/board-eligible specialists or academic specialists were consulted when applicable. During the on-site interview session, LIBERTY staff members confirmed (and the denial file reviews verified) that all authorization decisions to deny dental services were rendered by a licensed dental provider. The decision to deny a service authorization request was made by a licensed dentist in all 10 files reviewed confirming that only licensed dentists may render a decision to deny dental services. The NABD for the denial in whole, or in part, of a service authorization request was sent according to the required time frame in all 10 files reviewed. The NABD denial notification letter sent to the member in all 10 denial files reviewed did not identify the clinician who rendered the decision. The denial notification letter sent to the requesting provider, however, identified the clinician who rendered the decision. While the NABD in the denial files included reasons for the decision to deny the authorization, the reasons for the denial decision were not written in plain language. LIBERTY staff members stated during the on-site review that the NABD was revised and approved by the DHCFP on September 10, 2019, just prior to LIBERTY's compliance review. According to LIBERTY staff members, the revised NABD template letter was in the process of being updated in LIBERTY's UM software program with implementation scheduled for the end of September 2019. Please refer to Standard IX—<i>Grievances and Appeals</i>, Element 1 for additional findings.</p>			



**Appendix B. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
2020 Corrective Action Plan Compliance Review Tool
for LIBERTY Dental Plan of Nevada, Inc.**



Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
	<p>Recommendations: LIBERTY must ensure that its NABD template letter sent to members and the requesting provider is written in plain language and includes all requirements identified in federal regulations.</p>		
<p>Corrective Action Plan (Include required action, responsible individual, and completion date.)</p>	<p>Responsible Individual(s): Sydney Lee – Director, Quality Management Beatriz Angulo – Director, Claims Nevada</p> <p>Completion Date: 01/01/2020</p> <p>Action: Please see attached member NV Medicaid NOA Sample; LIBERTY has revised and added the placement of the “Reviewing Dentist” in the NOA form. LIBERTY is seeking approval of the NOA form from HSAG for implementation. Additionally, LIBERTY is in the process of updating all denial rationales including the denial rationales in questioned within the denial files reviewed. We have a target completion date of 01/01/2020.</p>		
<p>DHCFP Response (To be completed by DHCFP/HSAG.)</p>	<p>In the updated (2016) federal regulations, the notice sent to members when a decision is made to deny, reduce, or suspend a request for service was changed from a Notice of Action to a Notice of Adverse Benefit Determination. HSAG recommends LIBERTY update the title of the letter.</p> <p>The DHCFP accepts this CAP with HSAG’s recommendation. Evidence of implementation will be assessed during the 2020 compliance review.</p>		
2020 CAP Compliance Review			
<p>DBA Evidence of Compliance: <i>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.</i></p> <p>LIBERTY received approval from DHCFP for our remediation plan on March 15, 2020 and has since began implementation of the approved NOA sample which includes the name of the clinical reviewer. The template has been updated to comply with the federal update to “NABD” and is currently undergoing programing and testing and is expected to be in production as of June 30, 2020.</p> <p>LIBERTY has convened an ongoing workgroup that is responsible for conducting ongoing reviews of our denial rationales to ensure format and language is easily understood.</p>			



Appendix B. Division of Health Care Financing and Policy
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2020 Corrective Action Plan Compliance Review Tool
for LIBERTY Dental Plan of Nevada, Inc.



Standard X: Coverage and Authorization of Services			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
See attachments submitted for Section IX, Requirement 16 and 17.			
HSAG Findings: HSAG has determined that LIBERTY implemented the CAP for this element.			
Required Actions: None.			<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



Appendix C. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
SFY 2019–20 Compliance Review—Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.



SFY 2019–20 Compliance With Standards Review Tool CAP Template

Standard XI: Internal Quality Assurance Program

Reference	Requirement	Information Submitted as Evidence by the DBA ^{C-1}	Score
<i>DHCFP Contract Section 3.9.6.6(A-B)</i>	10. Provider Review a) Dentists and other health professionals review the process followed in the provision of dental services and outcomes. b) The DBA must provide feedback to health professionals and DBA staff regarding performance and patient health care outcomes.	Documents Submitted: 12. 2020 Dental Advisory Committee Charter 13. 2020 Peer Review Committee Charter 14. QM PP - Peer Review Committee Process Description of Process: LIBERTY’s Dental Advisory Committee as well as the Peer Review Committee identifies areas in which LIBERTY Providers are involved in the discussion, feedback, and performance of the overall QMI Program.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The DBA provided limited information to confirm that it provides feedback to health professionals and providers regarding performance and member healthcare outcomes outside of the external providers that happen to be present on the Dental Advisory Committee or Peer Review Committee. After the virtual review, the DBA provided an example of a provider newsletter with a narrative explaining that it had identified that providers often submit incomplete dental records for case reviews and, therefore, an article was published in the newsletter to remind providers of the importance of submitting complete dental records. However, this does not demonstrate that the DBA provided feedback on performance or member outcomes, either at the DBA level or provider-specific level. HSAG noted that the Utilization Management Program Description suggested that the DBA is profiling providers and sharing this feedback with providers. HSAG requested evidence to verify this was actually occurring and no provider profiles, or evidence that provider profiles were communicated to providers, were submitted. HSAG does acknowledge that the DBA discovered that the additional documentation requested		

^{C-1} The Information Submitted as Evidence by the DBA column was completed by the DBA and has not been altered by HSAG except for minor formatting.



**Appendix C. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
SFY 2019–20 Compliance Review—Corrective Action Plan Template
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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{C-1}	Score
	for this element was not submitted to the HSAG portal due to a manual uploading error and was later uploaded; however, this evidence was not considered as it was received after the submission due date.		
	Required Actions: The DBA must provide feedback to health professionals and DBA staff members regarding performance and patient healthcare outcomes. The DBA also must provide practice feedback to practitioners.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	<p>a) Specific plan(s) of action to bring the deficient element into compliance.</p> <p>As referenced above, after reviewing HSAG’s draft report, LIBERTY discovered that the additional documentation requested for this element was not submitted to the HSAG portal due to our manual uploading error (we inadvertently uploaded the same file twice). We take this error very seriously and have since enhanced our portal submission protocol to prevent future errors. The evidence which was inadvertently omitted from LIBERTY’s portal submission on 8/19/2020 demonstrates LIBERTY’s compliance throughout the audit lookback period. We are providing the 8/19/2020 files attached in addition to the narrative response below.</p> <p>Evidence of Compliance - Element #10:</p> <p>On at least a quarterly basis, LIBERTY’s Dental Care Management (DCM) team analyzes utilization data at the procedure code and office/provider level creating a transparent way to compare our network providers’ practice patterns against their peers. LIBERTY reviews network normative patterns, identifies outliers, and investigates the cause, allowing us an opportunity to develop action plans accordingly. Uploaded to the portal, is an example of the report that LIBERTY uses (see Nevada Utilization Report). Please note that LIBERTY only included a very small subset of the codes for illustration purposes due to the size of the report.</p> <p>When LIBERTY identifies providers, who are performing outside expected practice patterns (both over- and/or under-utilization of services), our staff dentists and our Nevada Dental Director engage the provider to educate them on program requirements, their performance in the context of their peers, and best practices. We have found this approach to be effective. Attached is a summary of a peer-to-peer call that took place (see Provider Service Report Redacted).</p> <p>After the call, LIBERTY monitors provider performance to determine if the identified issue has been corrected. The timeline for re-evaluation is related to the severity and the level of remediation needed (typically 90 days). We compare reports before and after the call to identify whether there is an improvement. Attached is a comparison report for an office (see Nevada Medicaid Child Comparison Date)</p>		



Appendix C. Division of Health Care Financing and Policy
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SFY 2019–20 Compliance Review—Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.



Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{C-1}	Score
	<p>There may be instances when the Dental Director requests additional documentation (such as x-rays/narratives) before claims are paid to review for medical necessity. Included with our submission is a letter that we sent to notify an office when we initiated the request and when we removed the request (see Transform Letter and Transform Off Letter).</p> <p>When offices are under-performing for a specific procedure code, such as sealants, we communicate with the providers to educate them on the importance of preventive care. Included in our submission is a letter regarding low sealants we send to offices (see Sealant Utilization Letter).</p> <p>Education provided by Nevada’s Dental Director in peer-to-peer fashion is the intervention most often needed to correct the issue. This communication between clinicians serves to create valuable, long-term partnerships between LIBERTY and our provider network to provide better service for the members.</p> <p>b) Department(s)/individual(s) responsible for completing the plan(s) of action LIBERTY’s Dental Care Management Department</p> <p>c) Due date for implementing each plan of action noted in the CAP Attached for your review and approval, LIBERTY is providing the following evidence:</p> <ol style="list-style-type: none"> 01. Nevada Utilization Report 02. Transform Letter - NV - 20191203-2_0 03. Transform Off Letter - NV – 20191216-2_0 04. Sealant Utilization Letter 2020.01.09 05. Provider Service Report_Redacted 06. Nevada Medicaid Child Comparison Data 02.26.2020 		
HSAG Response	<p>HSAG has determined that the DBA’s CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews. LIBERTY should also consider sharing information related to the DBA’s overall performance in various QI activities to the provider network.</p>		
DHCFP Approval	<p>DHCFP approves this CAP.</p>		



Appendix C. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
SFY 2019–20 Compliance Review—Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.



Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{C-1}	Score
<i>DHCFP Contract Section 3.9.9.6</i>	15. Program Modification <i>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 DBA. 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.</i>	Documents Submitted: 11. 2019 QMI Annual Program Evaluation - NV_FINAL Description of Process: LIBERTY’s QMI Program document and the effectiveness of the program is reviewed, evaluated and revised on an annual basis. The annual evaluation, revised program and work plan activities are submitted to the QMI Committee of LIBERTY Dental for review, input and reporting to the Board of Directors for approval. The QMI Committee is presented with the evaluation report, which is reviewed to formulate recommendations for continuous process improvement revisions. After the revisions have been approved, they are formally presented to the Board of Directors for review and approval.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: HSAG requested two examples of BOD meeting minutes to confirm compliance with providing the BOD with regular written reports. One example of what appeared to be a memo including an executive summary of a quarterly BOD meeting was submitted. After the virtual review, HSAG requested a second example. The DBA provided dashboard examples and Nevada Market Meeting minutes, all of which were dated outside of the time period of review. Additionally, it was unclear if the Nevada Market Meeting is equivalent to the BOD as its meeting minutes do not coincide with the topics included in the executive summary memo that was provided. Further, should the Nevada Market Meeting coincide with the BOD, agenda items included in the Nevada Market Meeting and level of detail in meeting minutes appeared inadequate for a BOD meeting. It was unclear if the executive summary memo is intended to represent meeting minutes, as it appears to be a		



**Appendix C. Division of Health Care Financing and Policy
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Standard XI: Internal Quality Assurance Program			
Reference	Requirement	Information Submitted as Evidence by the DBA ^{C-1}	Score
	summary of activities, but no minutes of discussion items. There was no documented follow-up discussion regarding any of the information provided within the report to the BOD in the Nevada Market Meeting minutes.		
	<p>Required Actions: The DBA must provide the BOD with 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 DBA. This activity must be documented in the minutes of the meetings of the BOD in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.</p>		
<p>Corrective Action Plan (Include required action, responsible individual, and completion date.)</p>	<p>a) Specific plan(s) of action to bring the deficient element into compliance LIBERTY Dental Plan of Nevada, Inc. (LIBERTY) and its respective Board of Directors (BOD) will review and document its review of the relevant materials on a quarterly basis, starting with Quarter 4, 2020.</p> <p>b) Department(s)/individual(s) responsible for completing the plan(s) of action LIBERTY’s Quality Management Department will generate a market specific (Nevada) quality management report that will be submitted to LIBERTY’s Corporate Secretary for presentation to the BOD on the quarterly basis as described above. As to the planned dates of presentation, it will be completed by the close of each calendar quarter (or shortly thereafter, given compilation of the results of the quarter’s activities).</p> <p>c) Due date for implementing each plan of action noted in the CAP LIBERTY will implement this process immediately, with the first presentation to the BOD due for December 2020 (Quarter 4, 2020).</p>		
HSAG Response	HSAG has determined that the MCO’s CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.		
DHCFP Approval	DHCFP approves this CAP.		



Appendix C. Division of Health Care Financing and Policy
Nevada Medicaid Managed Care
SFY 2019–20 Compliance Review—Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.



Standard XII: Cultural Competency Program			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
42 CFR §438.10(h)(1)(vii)	7. Information for all Members The DBA must make available in paper form upon request and electronic form, information about its network providers that includes the providers' cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.	Documents Submitted: 06. NM PP – Maintaining Provider Directories 07. QM PP – Provider Education Training Description of Process: See attached P&P for description of process.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
	Findings: The Spanish online provider directory did not identify if the provider received cultural competency training as required by federal regulation.		
	Required Actions: The DBA must identify in the provider directory if the provider received cultural competency training as required in federal regulation.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)	<p>a) Specific plan(s) of action to bring the deficient element into compliance LIBERTY's Provider Relations Department will add a custom attribute to record if a provider has completed cultural competency training within the last 12 months. Within the online directory there will be a "More Info" hyperlink that will indicate providers' Annual Compliance and Cultural Competency Training using a yes or no field indicator.</p> <p>b) Department(s)/individual(s) responsible for completing the plan(s) of action LIBERTY's Provider Relations and IT Departments will collaborate to implement pulling in cultural competency data into LIBERTY's online, Spanish and paper directories. This training is included in our annual compliance training and it will be specifically indicated if it has been completed in the directory. Provider Relations will be responsible for keeping the information current.</p> <p>c) Due date for implementing each plan of action noted in the CAP LIBERTY will implement this process by 12/1/2020.</p>		



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SFY 2019–20 Compliance Review—Corrective Action Plan Template
for LIBERTY Dental Plan of Nevada, Inc.**



Standard XII: Cultural Competency Program			
Reference	Requirement	Information Submitted as Evidence by the DBA	Score
HSAG Response	<p>Please note that the requirement for identifying whether the provider has completed cultural competence training has been removed from the updated federal regulations effective December 2020. While cultural competence training is no longer a requirement for the provider directory, CMS regulations continue to require DBAs to collect cultural competence data to be included in the provider directory.</p> <p>HSAG has determined that the DBA’s CAP is sufficient to ensure compliance with this element. Implementation of the CAP will be reviewed during future compliance reviews.</p>		
DHCFP Approval	DHCFP approves this CAP.		