Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

Calendar Year 2022 External Quality Review Compliance Review Report

for

Health Plan of Nevada

November 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

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

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

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

Description of the External Quality Review Compliance Review

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

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

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

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

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

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

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

Summary of Findings

Review of Standards

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

Table 1-2—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	12	10	2	0	**83%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	10	10	7	3	0	**70%**
Standard XIII—Health Information Systems	14	14	12	2	0	**86%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	37	2	3	**95%**
Total	**134**	**131**	**114**	**17**	**3**	**87%**

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

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

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

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

HPN achieved an overall compliance score of 87 percent, indicating adherence to many of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, and Health Information Systems as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

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

2. Methodology

Activity Objectives

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

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

Table 2-1—Compliance Review Standards

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

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

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

Pre-Site Review Activities:

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

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

Site Review Activities:

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

Post-Site Review Activities:

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

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

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

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

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

Description of Data Obtained

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

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

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

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

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	January 1, 2022–May 31, 2022
Information obtained through interviews	September 14, 2022
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all practitioners and organizations who completed the credentialing process between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member grievance files	Listing of all closed member grievances between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member appeal files	Listing of all closed appeals between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Nevada Medicaid managed care program between January 1, 2022–May 31, 2022

3. Corrective Action Plan Process

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

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

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

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

Appendix A. Review of the Standards

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

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. *Additionally:* a. *Prior to becoming a network provider, a provider who is a non-Medicaid enrolled provider must be referred to DHCFP's fiscal agent for completion of the Medicaid provider enrollment process.* b. *The MCO may execute network provider contracts pending the outcome of the screening, enrollment, and revalidation process of up to one hundred twenty (120) calendar days but must terminate a network provider immediately upon notification from DHCFP that the network provider cannot be enrolled, or the expiration of the 120-day period without Medicaid enrollment of the provider, and notify affected members.* c. *A provider must be credentialed in accordance with the requirements of the Contract in order to become a network provider.* 42 CFR §438.214(a) 42 CFR §438.214(b)(2) 42 CFR §438.214(e) Contract 7.6.2.1; 7.6.2.2.3; 7.6.2.2.4; 7.6.2.2.7; 7.6.2.3; 7.9.6	**HSAG Recommended Evidence:** • Policies and procedures • Process documentation describing how credentialing/recredentialing information is received, stored, reviewed, tracked, and dated. • Provider enrollment process documentation **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy whole document • HPN_Credentialing SOP_Verification Sources whole doc • HPN_Network Participation Standards pg 2 • HPN_State Verification Example • HPN_Revalidation Term Letter Template • HPN_Medicaid Enrollment Reminder Template • HPN_Provider Selection Process • HPN_Provider Termination Policy	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.* 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing form template (link to form is acceptable) • HSAG will also use the results of the File Reviews for Form NDOI-901 use **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy whole document • HPN_Network Participation Standards whole document • HPN_NV Initial Cred Application (NDOI-901) • Join Our Network - Doctor / Provider - Health Plan of Nevada	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: The MCO's policy listed the following practitioners who are not to be credentialed: • Certified Massage Practitioner • Certified Registered Nurse Anesthetist • Clinical Nurse Specialist • Dentists who are not oral surgeons • Licensed Practical Nurse • Registered Behavioral Therapist • Pathologist • Radiologist • Anesthesiologist • Emergency Room/Urgent Care Practitioner • Neonatologist		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**

- Respiratory Therapist
- Body Imagery

The MCO's policy also listed the following organizational provider types that are not to be credentialed:

- Laboratories
- Outpatient Physical Therapy
- Speech Pathology Providers
- Portable X-Ray Supplies
- Durable Medical Equipment Providers
- Hearing Aid Centers
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Group Homes
- Adult Day Care Centers

Additionally, the MCO's universe file for the review period included only three organizational providers, all of which were Ambulatory Surgery Centers (ASCs). During the site review, HSAG reviewers expressed their concern regarding the low volume of organizational providers being credentialed and recredentialed. Additionally, while some of the practitioners who were not being credentialed may be appropriate (e.g., practitioners who practice exclusively in an inpatient setting or free-standing facility and provide care to members only because the members are directed to the facility), HSAG also expressed concern with several provider types, including organizations, that were not being credentialed by the MCO. After the site review, the MCO explained that it verified that its provider types which require credentialing align with NCQA and the MCO's parent company, excluding clinical laboratories. The MCO indicated that it will update its credentialing policy to include clinical laboratories moving forward and will work to credential all existing contracted laboratories in the next six months. The MCO further explained that it will discuss updating the list of provider types that require credentialing beyond NCQA and the MCO's parent company's requirements with the credentialing committee. While the MCO is taking proactive steps to address this finding, in review of the MCO's contract with DHCFP, Section 7.6.2.3 requires the MCO to credential and recredential providers seeking network provider status with the MCO. Therefore, all providers who have network status with the MCO, and who would be displayed as a network provider in the provider directory, must complete the MCO's formal credentialing process. Additionally, a laboratory is a provider type licensed by the Nevada Division of Public and Behavioral Health (DPBH); therefore, it is unclear why clinical laboratories would not have been part of the MCO's credentialing process in the State of Nevada and for Nevada Medicaid. In response to the MCO's low volume of organizational providers being credentialed, the MCO explained that in late 2021 there was a significant turnover in credentialing staff that affected completion rates, and the MCO provided a chart that

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
demonstrated the historical volumes of organizational providers being credentialed and recredentialed during each quarter of 2020 and 2021. While these volumes were higher, they were still relatively low (minimum of three providers and maximum of 18 providers for initial credentialing per quarter; minimum of one provider and maximum of 18 providers for recredentialing per quarter). The provider types not historically credentialed by the MCO may explain this lower volume. Also, generally speaking, the number of providers being recredentialed was less than the providers being initially credentialed. In HSAG's experience, the volume of providers being recredentialed far exceeds the number of providers being initially credentialed for existing MCOs. The MCO should conduct an analysis of this general observation. **Recommendations:** The practitioner credentialing case file sample selections did not include a child/adolescent psychiatrist or psychologist provider type. As such, HSAG requested evidence of credentialing files for these provider types and corresponding screen shots of the provider directory to demonstrate that the MCO was collecting the age bands (0–6, 7–12, 13–17, and 18–21) served by these providers. After the site review, the MCO submitted a screen shot of a provider profile in the provider directory that included the following: "…Members 18 years of age or younger," but the directory did not break down the specific age bands. However, in the MCO's database, the profile for this provider included the breakdown of the age bands. As the MCO demonstrated the ability to document the age bands (and the provider directory was not in the scope of this year's compliance review), this finding was not considered a deficiency. However, HSAG strongly recommends that the MCO ensure that the specific age bands for all child/adolescent psychiatrist or psychologist provider types are being collected at the time of credentialing and included in the provider directory. The MCO further explained that with the implementation of the new contract, the MCO contacted all in-network psychiatrists and psychologists regarding the age bands, and very few of the providers responded; and if they did, it was to report that they accepted all ages. However, the MCO must require its providers to report the specific age bands for child/adolescent psychiatrists and psychologists at the time of credentialing as required by its contract with DHCFP. HSAG strongly recommends that the MCO make this a mandatory element in order for these provider types to be initially credentialed or recredentialed. Also, the age bands in the MCO's standard operating procedure (SOP) were outdated and must be updated accordingly. Lastly, HSAG was unable to locate the age limitations on the provider's profile when reviewing the online provider directory. In follow-up to this observation, the MCO explained that the age limitations were viewable on the "Group Affiliations" link. The MCO further explained that this information is supposed to pull for both the group and individual profiles and that staff are working to correct this issue. HSAG strongly recommends that the MCO proceed with its plan to correct the provider directory as this information is required to be made available to members. As HSAG reviewers were challenged to locate this information without direction from the MCO, members may also be challenged to locate this information. Implementation of HSAG's recommendations will be evaluated during future compliance reviews. The MCO may receive a score of *Not Met* if these recommendations are not implemented.		
Required Actions: The MCO must follow a documented process for credentialing and recredentialing network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorder (SUD), and LTSS providers. If State regulations or provider licensure laws conflict with NCQA standards, State regulations and provider licensure laws control the credentialing process. In accordance with the MCO's contract with DHCFP (Section 7.6.2.3), the MCO must credential and recredential providers seeking network provider status with the MCO.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Nondiscrimination		
3. The MCO network provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 Contract 7.6.2.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy pg 12	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** In response to HSAG's question related to a formal review process to monitor for discriminatory practices (e.g., annual review of credentialing denials), MCO staff members explained that the process had stopped during the coronavirus disease 2019 (COVID-19) pandemic but would resume immediately. HSAG strongly recommends that the MCO resume its formal review process to support the prevention of and monitoring for discriminatory practices as planned. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
4. The MCO may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCO declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the MCO must comply with the requirements specified in 42 CFR §438.214.	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices • Provider notice template • Example of one individual and one organizational executed provider contracts **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy pg 1, 14 • HPN_Initial Nevada Network Denial Letter Template	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.12 (a)(1-2) Contract 7.6.2.2.5	• HPN_Individual Contract • HPN_Organizational Contract	
MCO Description of Process: No organizational contracts were executed within the lookback period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Excluded Providers		
5. The MCO may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. a. *The MCO's written policies and procedures for its credentialing process complies with 42 CFR §1002.3.* 42 CFR §438.214(d)(1) Contract 7.6.2.2.2 Contract 7.6.2.3	**HSAG Recommended Evidence:** • Policies and procedures • Three consecutive months of ongoing monitoring reports/documentation **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy: pg 22, 32, 38 • HPN_SanctionedDebarredExcluded Policy • HPN_DHCFP MASTER Exclusions thru 3.22.22 • HPN_DHCFP MASTER Exclusions thru 4.5.22 • HPN_DHCFP MASTER Exclusions thru 5.24.22_NoUpdates (5.24.22) • HPN_MONTHLY REPORTS-FEDERAL Provider Vendor Employee Sanctions - March • HPN_MONTHLY REPORTS-FEDERAL Provider Vendor Employee Sanctions - April • HPN_MONTHLY REPORTS-FEDERAL Provider Vendor Employee Sanctions - May	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
State Requirements		
6. *If the MCO denies credentialing or does not extend a provider contract to a provider where the denial is due to the MCO's concerns about provider fraud, integrity, or quality, the MCO reports this to the State's Provider Enrollment Unit within fifteen (15) calendar days.* 42 CFR §438.214(e) Contract 7.6.2.3.3	**HSAG Recommended Evidence:** • Policies and procedures • One example of timely report to Provider Enrollment Unit (date of the denial and the date the provider was reported to the Provider Enrollment Unit must be included) **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy pg 17 • HPN_Provider Termination Policy • HPN_Denied Cred Report to State_2022.01.27 • HPN_Denied Cred Report to State_2022.03.24 • HPN_Denied Cred Report to State_2022.04.28	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
7. *The MCO must have written policies and procedures for credentialing and recredentialing that are in accordance with Section 7.9.6 of the Contract.* a. *The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures.* i. *The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.* ii. *The MCO identifies those practitioners who fall under its scope of authority and action. This must include, at a minimum, all physicians and other licensed independent practitioners included in the MCO's network.* b. *Changes to the credentialing process will need to be provided in writing to the State's Provider Enrollment Unit thirty (30) calendar days prior to the change. If the change is unanticipated, the MCO will notify the State's Provider Enrollment unit within five (5) calendar days of the change.* 42 CFR §438.214(e) Contract 7.6.2.3.6; 7.9.6.2-7.9.6.4	**HSAG Recommended Evidence:** • Policies and procedures • One example of report of credentialing process change to DHCFP (the effective date of the change and the date the process change was reported to DHCFP must be provided) • Governing body approval of credentialing policies and procedures • DHCFP approval of credentialing policies and procedures • Credentialing committee charter • Three consecutive examples of credentialing committee meeting minutes **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy pg 1, 3, 7, 40 • HPN_Committee Meeting Minutes_1.7.22 • HPN_Committee Meeting Minutes_1.20.22 • HPN_Committee Meeting Minutes_2.17.22	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There is no charter for the Credentialing Committee, however, the credentialing policies 300.01 and 300.02 outline the purpose, structure and responsibilities of the Credentialing Committee. This policy is reviewed no less than annually.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While MCO staff members explained that the credentialing policies were submitted to DHCFP as part of the implementation process of the new contract and were recently resubmitted to DHCFP after the time period of review, HSAG recommends that the MCO clearly delineate the requirements of sub-element (b) in its policy, procedure, and/or workflow to ensure staff awareness of this reporting requirement. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
8. *If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities, there must be a written description of the delegated activities, and the delegate's accountability for these activities.* a. *There must be evidence that the delegate accomplished the credentialing activities.* b. *The MCO must monitor the effectiveness of the delegate's credentialing and reappointment or recertification process.* 42 CFR §438.214(e) Contract 7.6.2.3.7	**HSAG Recommended Evidence:** • Policies and procedures • Delegation agreement template • Two examples of an executed delegation agreement for credentialing • Two examples of evidence to demonstrate credentialing monitoring, including credentialing completion oversight **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy pg 26-29 • HPN_EyeMed Audit Results	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Completed oversight on only one delegate during the lookback period. Please see executed agreements in the Delegate Case Files.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, Sierra Health and Life Insurance Company was the delegated credentialing agent for the MCO. During the site review, MCO staff members explained that the MCO is owned by Sierra Health and Life Insurance Company; therefore, Sierra Health and Life is not a delegated entity, and there is no written delegated arrangement between the two companies.		
Required Actions: None.		
File Reviews		
9. The MCO complies with individual practitioner credentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214(e) Contract 7.6.2.3.1; 7.6.2.3.2	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Site review process flow • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials)	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• HSAG will also use the results of the Practitioner Credentialing File Reviews	
	Evidence as Submitted by the MCO: • HPN_Credentialing SOP_Verification Sources whole doc • HPN_Cred-Recred Policy pg 32, 34-36 • HPN_NV Initial Cred Application (NDOI-901) • HPN_Medical Site Visit Assessment • HPN_Initial_Nevada Network Denial Template	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The case file review identified discrepancies in the way sanctions/exclusions queries were documented. For three cases, notes indicated that the "State Specific MAC Organization" was verified via the Medicare Opt-Out List, suggesting they were one in the same. For two cases, separate line items were listed for "State Specific MAC Organization" and "Medicare Opt-Out List," suggesting they were two different queries. While MCO staff members were unable to clarify these discrepancies during the site review, staff members verbalized that a system conversion occurred in August 2021 which may have resulted in the data discrepancies. However, it is unclear how a system conversion in August 2021 would affect data entered in 2022. The case files also demonstrated that Medicare/Medicaid sanctions and exclusions were verified via the Office of Inspector General (OIG), System for Award Management (SAM), and Medicare Opt-Out List, but the checklist did not identify that the MCO queried the Medicare Preclusion List, Social Security Administration (SSA) Death Master File (DMF), or the Nevada Medicaid Sanctions/Exclusions List. While the MCO consistently conducted primary source verification (PSV) of Nevada licensure, some providers also reported licenses in other states. When asked if the MCO conducts PSV of all state-specific licenses to screen for disciplinary action, MCO staff members explained that they rely on the National Practitioner Data Bank (NPDB) to monitor for any State sanctions or exclusions. As the MCO's contract with DHCFP does not stipulate which databases must be queried at the time of credentialing, this observation was not considered a deficiency; however, HSAG will be recommending that DHCFP identify the databases which must be queried in contract for consistency across the managed care plans for Nevada Medicaid. Also, while the MCO adhered to NCQA time limit verification standards, there appeared to be an excessive delay in initiating the credentialing process after receipt of the application in some instances. HSAG will be recommending that DHCFP define a time frame standard to complete the initial credentialing process (e.g., 60 or 90 calendar days from receipt of a complete application to the notice of the credentialing decision to the provider) for consistency across the managed care plans for Nevada Medicaid. Further, while it was the MCO's process to send providers welcome letters, after the site review, the MCO reported that a letter was not available for one		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
case file. It is unknown why this letter was not available, and the MCO did not explain why. After the site review, the MCO submitted a welcome letter for a provider for a second file; however, it was dated in 2012. It is unknown why this letter was 10 years old when the provider was reported by the MCO as being initially credentialed in 2022, and the MCO did not provide any further explanation. For two other cases, the welcome letter was dated almost two months after the credentialing decision, which appears to be an excessively long time frame. As a review of denial letters (not approval letters) was being evaluated during this compliance review, HSAG did not consider these observations a deficiency; however, HSAG will monitor the MCO's compliance with sending providers welcome letters during future compliance reviews. Lastly, proofs of verification of the Nevada State Board of Pharmacy (BOP) were not located in all files. As such, HSAG recommends that these proofs or screen shots be saved in each file as a best practice. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
10. The MCO complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool. 42 CFR §438.214 Contract 7.6.2.3.4	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Quality data review process documentation, including source data • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Practitioner Recredentialing File Reviews **Evidence as Submitted by the MCO:** • HPN_Credentialing SOP_Verification Sources • HPN_Cred-Recred Policy pg 32 - 33 • HPN_NV ReCred Application (NDOI-901) • HPN_ReCred_Nevada Network Denial Letter Template	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: No adverse recredentialing decisions were made during the lookback period.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The case file review indicated that a provider performance review occurred at the time of recredentialing and included a review of the following categories: "QM/RM/CRR," "Utilization Management," and "Satisfaction Survey." However, in further discussion with MCO staff members, utilization management data were not proactively being assessed for provider-specific performance (e.g., over- and underutilization of services). MCO staff members reported that they are not specifically looking at utilization management and that this line item is part of the MCO's checklist template. The MCO must define the utilization management data and thresholds being considered. Additionally, one case file did not include "Satisfaction Survey" on the checklist. MCO staff members explained that if an item was not on the list, there were no data available for that provider. However, the MCO should be documenting in the recredentialing file that this activity was considered but that no data were available to demonstrate compliance with this requirement.		
Required Actions: The MCO must comply with all recredentialing requirements in accordance with its contract with DHCFP.		
11. The MCO complies with organizational credentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Credentialing File Reviews **Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy pgs 37-39 • HPN_Initial_Nevada Network Denial Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: No adverse organizational credentialing decisions were made during the lookback period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the universe file submitted by the MCO included only one organizational provider (an ASC) which was initially credentialed during the time period of review. HSAG finds this low volume concerning. Refer to Element 2 of this standard for additional findings.		
Required Actions: None.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
12. The MCO complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Recredentialing File Reviews	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the MCO: • HPN_Cred-Recred Policy pgs 37-39 • HPN_ReCred_Nevada Network Denial Letter Template	
MCO Description of Process: No adverse organizational recredentialing decisions were made during the lookback period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the universe file submitted by the MCO included only two organizational providers (two ASCs) which were recredentialed during the time period of review. HSAG finds this low volume concerning. Refer to Element 2 of this standard for additional findings.		
Required Actions: None.		

Standard VIII—Provider Selection						
Met	=	10	X	1	=	10
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	12	Total Score		=	10
Total Score ÷ Total Applicable					=	83%

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO must, for medical records and any other health and enrollment information that identifies a particular member, use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable. The MCO must: a. *Establish in writing, and enforce, policies and procedures on confidentiality, including confidentiality of medical records.* b. *Ensure patient care offices/sites have implemented mechanisms to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.* c. *Hold confidential all information obtained by its personnel about members related to their examination, care, and treatment and shall not divulge it without the member's authorization, except as required or permitted by law.* 42 CFR §438.224 Contract 7.4.8; 7.9.9.1-7.9.9.3	**HSAG Recommended Evidence:** • Policies and procedures • Disclosure form(s) • Staff and provider training materials • Provider contract template • Staff and provider monitoring documentation Evidence as Submitted by the MCO: • HPN_Annual Privacy Training – whole document • HPN_Consulting Provider Contract Template pg 6, 23 • HPN_CR 300 Cred-Recred Policy pg 34-36 • HPN_Medical Site Visit Assessment • HPN_PCP Contract Template pg 7, 23 • HPN_Provider Summary Guide Medicaid pg 13 • HPN_RoI Auth Example • HPN_UHC Privacy Notice Policy – whole document • HPN_UHG Code of Conduct pgs 18-21 • HPN_UHG Privacy Policy Manual– whole document • HPN_Website Privacy page • HPN_WRHCO 343 Confidentiality of Patient Records	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Uses and Disclosures of PHI		
2. The MCO and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCO is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCO has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1) Contract 7.9.9.3.1-7.9.9.3.3; 7.9.9.4; 7.9.9.5	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template • Delegate agreement/contract • HIPAA incident tracking mechanism **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual Section 2.100 – 2.1130, pages 27 – 46 (page numbers reference page of the pdf and not the page as indicated at the bottom of the each page within the pdf) • HPN_WRHCO 343 Confidentiality of Patient Records • HPN_UHC Disclosures to Third Parties Policy pgs 2-3 • HPN_Annual Privacy Training 2022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
3. The MCO, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCO's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2-4)	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for processing requests • Training materials • Business associate agreement template **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 1.400 – 1.440, Pages 21 – 24 • HPN_UHC Minimum Necessary Policy pg 2 • HPN_Annual Privacy Training 2022 pg 38-40, 111-115	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Minimum Necessary		
4. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCO must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 2.000 pg 27 • HPN_UHC Minimum Necessary Policy pg 1 • HPN_Annual Privacy Training pg 35	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
5. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 45 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law. f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR. 45 CFR §164.502(b)(2)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual Section 3.300 pg. 49 • HPN_UHC Minimum Necessary Policy pgs 2-3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Uses and Disclosures Requiring Authorizations		
6. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for the use or disclosure of PHI, the covered entity must provide the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual Section 3.310 – 3.350, pages 49-51 • HPN_RoI Auth Example	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4)		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Privacy Rights		
7. The MCO complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the MCO:** • HPN_Member Handbook_Confidentiality pg 87-88 • HPN_UHG Privacy Policy Manual, Section 3.400-3.420, page 51-53 • HPN_UHC Restrictions Policy	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN Medicaid has not received any requests to access PHI during the audit period. There is no form for the request; any written request is accepted.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations**: Although the MCO did not require members to complete an MCO-developed form when requesting access to their PHI or exercising other individual rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the MCO required the requests to be in writing. Therefore, HSAG recommends that the MCO develop template forms for members to access and use when exercising their individual rights and requesting		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
information or action from the MCO. This will help ensure that the member provides the MCO with the information necessary to complete the request. This recommendation applies to elements 7–10 of this standard. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
8. The MCO complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The MCO must act on a request for access no later than 30 days after receipt of the request. b. The MCO must provide the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCO and member. 45 CFR §164.524	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 5.000 – 5.180, pages 57 - 60 • HPN_Annual Privacy Training 2022 pg 111-115 • HPN_Member Handbook_Confidentiality pg 87 • HPN_UHC Right to Inspect Policy pg 3, 6 • HPN_MS Member Right to Access PHI pg. 3-4	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN Medicaid has not received any requests to access PHI during the audit period. There is no form for the request; any written request is accepted.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
9. The MCO complies with the member's right to have the MCO amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCO complies with the requirements under 45 CFR §164.526. a. The MCO must act on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 5.400 – 5.480, pages 60 - 63 • HPN_UHC Right to Request and Amendment Policy pg.1, 4-5 • HPN_MS Right to Amend PHI pg 3-4 • HPN_Member Handbook_Confidentiality pg 87	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN Medicaid has not received any requests to amend PHI or a record during the audit period. There is no form for the request; any written request is accepted.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. The MCO complies with the member's right to receive an accounting of disclosures of PHI made by the MCO in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The MCO must act on the member's request for an accounting, no later than 60 days after receipt of such a request.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Process workflow • Tracking documentation • Request form template • Three examples of completed request documentation	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
b. The MCO must document the accounting of disclosures and retain the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528	**Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 7.000 – 7.800, pages 63 - 66 • HPN_UHC Accounting of Disclosures Policy • HPN_Member Handbook_Confidentiality pg 88 • HPN_Disclosure Log	
MCO Description of Process: HPN Medicaid has not received any requests for an accounting of disclosures during the audit period. There is no form for the request; any written request is accepted. HPN documents all disclosures and can provide the information upon request.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Notice of Privacy Practices		
11. The MCO's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCO, and of the member's rights and the MCO's legal duties with respect to PHI. a. The MCO must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The MCO must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1)(i-viii) 45 CFR §164.520(c)(1-3)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form • Copy of notice of privacy practices **Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 3.100 – 3.140, pages 46 – 49. • HPN_UHC Privacy Notice Policy pgs 2-3, 6 • HPN_Member Handbook_Confidentiality pg 85	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: Although the Privacy Policy Manual stipulated all Notice of Privacy Practices components under federal rule, the Health Plan Notices of Privacy Practices included as part of the January 2022 member handbook reflected the following gap:		

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Requirement	**Supporting Documentation**	**Score**

- In accordance with 45 CFR §164.520(b)(1), the header in the Notice of Privacy Practices (NPP) must include the following statement, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*"* The MCO's header indicated, "THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY." Although this statement is similar, it does not indicate within the header statement that the notice also describes how medical information will be disclosed.

After the site review, the MCO stated, "we are of the opinion that our NPPs meet the requirements of CFR Sec. 164.520(b) and our obligations to comply with a fifth (5th) grade reading requirements in accordance with the Flesh Kincaid Grade Level pursuant to regulatory and contractual requirements we have with the various state Medicaid agency's we service." Additionally, the MCO provided comments from the Department of Health and Human Services (HHS), including:

> Additionally, the Privacy Rule requires that the NPP be written in plain language, and we note that some covered entities may have obligations under other laws with respect to their communication with affected individuals. For example, to the extent a covered entity is obligated to comply with Title VI of the Civil Rights Act of 1964, the covered entity must take reasonable steps to ensure meaningful access for Limited English Proficient persons to the services of the covered entity, which could include translating the NPP into frequently encountered languages. In addition, we agree with the commenters who suggested that covered entities have flexibility and discretion to determine how to draft and prepare their NPPs. Because each NPP will vary based on the functions of the individual covered entity, there is no 'one size fits all' approach. However, we continue to explore options for making model or best practice language available.

While HSAG agrees that MCOs have the flexibility to update their notices to comply and align with State requirements, HHS is very clear within the Federal Register that "…covered entities must include prominent and specific language in the notice that indicates the importance of the notice. This is the only specific language we require covered entities to include in the notice. The header must read, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY." Please refer to the Federal Register at https://www.federalregister.gov/documents/2000/12/28/00-32678/standards-for-privacy-of-individually-identifiable-health-information.

Recommendations: Although the Notice of Privacy Practices published on the MCO's website included the appropriate header statement, this version of the notice was not provided as evidence for this compliance review and is not the same version of the Notice of Privacy Practices provided to members on enrollment. As such, the MCO should consider updating the Notice of Privacy Practices in the member handbook to align with the Notice of Privacy

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Practices published to the MCO's website. This version of the notice was also more comprehensive and was in a more user-friendly format. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must provide members with a notice that contains the elements required by 45 CFR §164.520(b)(1)(i–viii).		

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

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. *The MCO has a staff person dedicated to the Contract who acts as the Grievances and Appeals Coordinator to manage member and provider disputes arising from the MCO's Grievance and Appeals System.* a. *The MCO shall have sufficient support staff (clerical and professional) available to process grievance and appeals in accordance with the requirements of the Contract.* Contract 7.2.1.2.12; 7.8.10.5.6	**HSAG Recommended Evidence** • Job description • Organizational chart • Training materials **Evidence as Submitted by the MCO** • HPN_Appeals Mgr JD • HPN_Grievance Mgr JD • HPN_Grievance Policy pg 2 • HPN_Appeals Policy pg 4 • HPN_QOC Org Chart • HPN_A&G New Hire Training Schedule	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. The MCO defines a grievance as an expression of dissatisfaction *or making a complaint* about any matter other than an adverse benefit determination (ABD)*, regardless of whether the communication requests any remedial actions*. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an	**HSAG Recommended Evidence** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 69, 75 (handbook page references refer to the page number in the pdf, and not the page number at the bottom of the document) • HPN_Grievance Policy pg 2	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
extension of time proposed by the MCO to make an authorization decision. 42 CFR §438.400(b) 42 CFR §438.228 Contract 7.8.10.2		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
3. A member may file a grievance with the MCO at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §438.228 Contract 7.8.10.6.1; 7.8.10.6.4	**HSAG Recommended Evidence** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • Three examples of grievances submitted by provider or authorized representative with member written consent **Evidence as Submitted by the MCO** • HPN_Grievance Policy pg 3 • HPN_Member Handbook_G & A pg 69, 75	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: HPN did not have any Providers filing a grievance on behalf of the member during the audit period.		
HSAG Findings: For most grievances reviewed as part of the case file review, the member filed the grievance. However, one grievance was filed by the mother of an adult member, and there was no evidence to support that the MCO attempted to obtain consent or that the mother was the legally authorized representative. Additionally, during the site review, MCO staff members confirmed they do not obtain consent when a grievance is filed by a provider or authorized representative on behalf of a member; instead, they would work the grievance and then would send the acknowledgment and resolution letters to the member. However, federal rule requires that written consent be obtained from a provider or an authorized representative when a grievance is being filed on a member's behalf.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: The member handbook supported that the member could file a grievance at any time but did not include that providers and authorized representatives may also file a grievance with the member's written consent. HSAG recommends that the MCO update the member handbook to explain that providers or authorized representatives may file a grievance on the member's behalf with the member's written consent. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: When a grievance is filed by a provider or an authorized representative on behalf of the member, the MCO must obtain the member's written consent.		
4. The member may file a grievance either orally or in writing. a. *If a grievance is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt.* 42 CFR §438.402(c)(3)(i) 42 CFR §438.228 Contract 7.8.10.6.1	**HSAG Recommended Evidence** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 75 • HPN_Grievance Policy pg 3-4	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Handling of Grievances		
5. The MCO must acknowledge receipt of each grievance. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**HSAG Recommended Evidence** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO** • HPN_Grievance Policy pg 2 • HPN_Grievance Ack Letter Template	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. The MCO must ensure that the individuals who make decisions on grievances are individuals a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. 42 CFR §438.406(b)(2) 42 CFR §438.228 Contract 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.2; 7.8.10.10.4.3	**HSAG Recommended Evidence** • Policies and procedures • Organizational chart • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO** • HPN_Grievance Policy pg 3 • HPN_A&G Medicaid Org Chart • HPN_QOC Org Chart • HPN_Grievance Medical Director Org Chart	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely Resolution and Notification of Grievances		
7. The MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. a. The MCO must resolve the grievance and send *written* notice to the affected parties *no later than ninety (90) calendar days* from the day the MCO receives the grievance. b. *The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.* c. The notice must meet the standards described at 42 CFR §438.10 *and include the results of the resolution process and the date it was completed.* 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract 7.8.10.9.1.1; 7.8.10.11.1	**HSAG Recommended Evidence** • Policies and procedures • Grievance resolution notice template • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO** • HPN_Grievance Policy pg 2-3 • HPN_Grievance Outcome Letter Template	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: Through the case file review, MCO staff members demonstrated that they were contacting members in most instances to inform them that the grievance had been resolved and that they would receive a written notification. However, the MCO staff members were not providing details of the resolution unless requested by the member during the call. The intent of the requirement is that members are being provided with detailed information about the actual resolution of the grievance, and not that the grievance was concluded. **Recommendations:** The member handbook stated that grievances will be resolved within 90 days; however, the acknowledgement letters to members indicated the grievance would be resolved within 30 days. HSAG recommends that the MCO update its member-facing materials to consistently provide the time frame in which grievances will be resolved. Implementation of this recommendation will be evaluated during future compliance reviews. Additionally, HSAG is also making a recommendation to DHCFP to reduce the current 90-day time frame allowance.		
Required Actions: The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
8. The MCO may extend the time frame for resolving grievances by up to fourteen (14) calendar days if a. The member requests the extension; or b. The MCO shows *to the satisfaction of DHCFP* that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract 7.8.10.9.3	**HSAG Recommended Evidence** • Policies and procedures • Three examples of grievances with extended time frame • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO** • HPN_Provider Summary Guide Section 8.8 pg 6 • HPN_Member Handbook_G & A pg 75 • HPN_Complaints_Closed_010122-053122	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN does not any examples of extensions because we have an internal standard of resolving grievances within 30 days and have provided a log showing that we meet that timeframe. An extension would only apply beyond the 90 day requirement. HPN has never had a member request an extension for resolution of a Grievance.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. However, please see additional related findings under Element 9 of this standard. Of note, the case file review and MCO staff members confirmed that no grievance resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		
9. If the MCO extends the grievance resolution time frame not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.	**HSAG Recommended Evidence** • Policies and procedures • Three examples of grievances with extended time frames (evidence of DHCFP approval to extend the time frame, oral notice of the extension to the member, written notice of the extension to the member must be included) • Grievance extension template letter • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO**	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 7.8.10.9.3	• HPN_Provider Summary Guide Section 8.8 pg 6 • HPN_Member Handbook_G & A pg 75 • HPN_Complaints_Closed_010122-053122	
MCO Description of Process: HPN does not have any examples of extensions because we have an internal standard of resolving grievances within 30 days and have provided a log showing that we meet that timeframe. An extension would only apply beyond the 90 day requirement. HPN has never had a member request an extension for resolution of a Grievance.		
HSAG Findings: Although the Provider Summary Guide and member handbook indicated that the time frame for resolving grievances may be extended by 14 days if the extension will benefit the member, there was no evidence provided to support the process that must occur if an extension is taken, including that the MCO has a process in place to contact the member to explain the delay, and within two days give the member written notice of the reason why the time frame is being extended and that they can file a grievance if they disagree with the decision. Although the MCO staff indicated that they have not had a grievance extension, the MCO must have a process in place to ensure that, should an extension be necessary in the future, MCO staff members are aware of the process that must be followed. Additionally, if the acknowledgement letters indicate that the grievance will be resolved in 30 days, which is internal policy, the member should be notified of an extension if the grievance will not be resolved within 30 days.		
Required Actions: If the MCO extends the grievance resolution time frame not at the request of the member (after DHCFP's approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay; and within two calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.		
Appeals General Requirements		
10. The MCO defines an appeal as a review by the MCO of an ABD. 42 CFR §438.400(b) 42 CFR §438.228 Contract 7.8.10.3	**HSAG Recommended Evidence** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 2 • HPN_Provider Summary Guide Section 8.10 pg 7 • HPN_Member Handbook_G & A pg 69 • HPN_Appeal Rights pg 2	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
11. The MCO may have only one level of appeal for members. 42 CFR §438.402(b) 42 CFR §438.228 Contract 7.8.10.5.2	**HSAG Recommended Evidence** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 1	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
12. The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.410(a-b) 42 CFR §438.228 Contract 7.8.10.5.3	**HSAG Recommended Evidence** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 5-7 • HPN_Provider Summary Guide Section 8.10 pg 8 • HPN_Appeal Rights pg 2	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. Following receipt of a notification of an ABD by an MCO, the member has sixty (60) calendar days from the date on the ABD notice in which to file a request for an appeal to the MCO. 42 CFR §438.402(c)(2)(ii) 42 CFR §438.228 Contract 7.8.10.6.3	**HSAG Recommended Evidence** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 69 • HPN_Appeals Policy pg 6 • HPN_Appeal Rights pg 1 • HPN_Appeals_Closed_010122 – 053122 • HPN_Provider Summary Guide pg 7	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If an appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. The MCO must not require the member to submit a written appeal after making an oral appeal.* 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 7.8.10.6.1	**HSAG Recommended Evidence** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 70-73 • HPN_Appeals Policy pg 6 • HPN_Appeal Rights pg 1-2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO provided evidence to support that it would obtain members' written consent when appeals are being filed on their behalf, its policy indicates, "… the Provider must first obtain the Enrollee's written permission with the exception of an expedited appeal." Therefore, HSAG strongly recommends that the MCO remove the language stipulating there are exceptions to obtaining written permission. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Handling of Appeals		
15. If the MCO denies a request for expedited resolution of an appeal, it must a. Transfer the appeal to the time frame for standard resolution *of no longer than thirty (30) calendar days from the day the MCO receives the appeal.* b. Follow the requirements in 42 CFR §438.408(c)(2), including i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision. 42 CFR §438.406(b)(1) 42 CFR §438.410(c) 42 CFR §438.228 Contract 7.8.10.5.3	**HSAG Recommended Evidence** • Policies and procedures • Denied request for an expedited appeal time frame letter template • Three examples of a denied request for an expedited appeal resolution (oral and written notice to the member must be included) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 7 • HPN_Expedite to Standard Letter • HPN_Provider Summary Guide pg 8 • HPN_Member Handbook_G & A pg 70 • HPN_Example 15 – File 2_Redacted	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the case file review demonstrated that the MCO had a good process to notify members (orally and in writing) when expedited appeal requests do not meet criteria and that a written appeal is not being required when the appeal is requested orally, the Appeals policy on page 7 indicated, "If an enrollee's oral request for an expedited appeal is transferred to standard appeal processing, a written appeal will not be required." Since a written appeal is never required, HSAG strongly recommends that the MCO update its policy to remove any references to requiring a written appeal. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
16. The MCO must acknowledge receipt of each appeal. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**HSAG Recommended Evidence** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 6 • HPN_Appeal Ack Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
17. The MCO must ensure that the individuals who made decisions on appeals are individuals a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.406(b)(2)	**HSAG Recommended Evidence** • Policies and procedures • Organizational chart • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pgs 4-5 • HPN_ Medical Director Org Chart	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.1; 7.8.10.10.4.3		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
18. The MCO must provide that oral inquiries seeking to appeal an ABD are treated as appeals. 42 CFR §438.406(b)(3) 42 CFR §438.228 Contract 7.8.10.10.5	**HSAG Recommended Evidence** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
19. The MCO must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCO must inform the member of the limited time available for this sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.406(b)(4) 42 CFR §438.228 Contract 7.8.10.9.2; 7.8.10.10.6	**HSAG Recommended Evidence** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 7 • HPN_Appeal Rights pg 2 • HPN_ABD Notice Template	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
20. The MCO must provide the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the ABD. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in 42 CFR §438.408(b) and (c). 42 CFR §438.406(b)(5) 42 CFR §438.228 Contract 7.8.10.10.7	**HSAG Recommended Evidence** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeal Rights pg 2 • HPN_Appeals Policy pg 6 • HPN_ABD Notice Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Resolution and Notification of Appeals		
21. The MCO must resolve standard appeals and send *written* notice to the affected parties as expeditiously as the member's health condition requires, but *no later than thirty (30) calendar days* from the day the MCO receives the appeal. 42 CFR §438.408(a)	**HSAG Recommended Evidence** • Policies and procedures • Tracking documentation • Appeal resolution letter template • HSAG will also use the results of the Appeal File Review	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(b)(2) 42 CFR §438.228 Contract 7.8.10.9.1.2; 7.8.10.11.1	**Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 6 • HPN_Appeal Rights pg 1 • HPN_Appeals_Closed_010122 – 053122	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
22. The MCO must resolve expedited appeals and send *written* notice to the affected parties no later than seventy-two (72) hours after the MCO receives the appeal. a. *The MCO is required to make a good faith effort to provide an oral notice of the disposition in addition to the required written notice.* 42 CFR §438.408(b)(3) 42 CFR §438.228 Contract 7.8.10.9.1.3; 7.8.10.11.1	**HSAG Recommended Evidence** • Policies and procedures • Tracking documentation • Appeal resolution letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 7 • HPN_Rpt Member Appeals_Closed_ • HPN_Appeal Denial Letter • HPN_Appeal Rights pg 1 • HPN_Appeals_Closed_010122 – 053122	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO demonstrated that all expedited appeals were processed within 72 hours as required, the MCO's member handbook indicated, "We must decide on an expedited appeal no later than 72 hours, three calendar days, after we get your appeal." Because expedited appeal time frames must adhere to 72 hours and not three calendar days, HSAG strongly recommends that the member handbook be updated with accurate language. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
23. The MCO may extend the standard or expedited appeal resolution time frames by up to fourteen (14) calendar days if a. The member requests the extension; or b. The MCO shows *to the satisfaction of DHCFP* that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.408(c)(1) 42 CFR §438.228 Contract 7.8.10.9.3	**HSAG Recommended Evidence** • Policies and procedures • Three examples of appeals with extended time frames • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_ Appeals Policy pg 7 • HPN_Appeal Rights pg 1 • HPN_14-Day Extension Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN does not have any examples of extended timeframes during the audit period of 1/1/22-5/31/22		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that no appeal resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		
24. If the MCO extends the standard or expedited appeal resolution time frames not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. c. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	**HSAG Recommended Evidence** • Policies and procedures • Three examples of appeals with extended timeframes (evidence of DHCFP approval to extend the time frame, oral notice of the extension to the member, written notice of the extension to the member must be included) • Appeal extension letter template • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 7 • HPN_14-Day Extension Letter	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(c)(2) 42 CFR §438.228 Contract 7.8.10.9.3		
MCO Description of Process: HPN does not have any examples of extension requests during the audit period of 1/1/22-5/31/22.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that no appeal resolution time frame extensions were applied during the time period under review. **Recommendations:** Although documentation provided by the MCO met the intent of the requirement, the MCO's 14-Day Extension Letter included language that may be misleading to the member. The letter stated, "HPN will complete the review and notify you in writing of our decision when we get the records from your physician or when 14 calendar days have passed, whichever comes first." Because the extension letter may be sent prior to the original appeal resolution time frame expiring, HSAG recommends that the MCO consider revising the language within the extension letter to make it clear that the MCO has the appeal time frame of 30 days plus an additional 14 days to make the appeal determination. The MCO could consider adding the dates a decision will be made, and notice sent. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
25. In the case that the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract 7.8.10.9.4	**HSAG Recommended Evidence** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • Three examples of an appeal not resolved timely (written notice to the member must be included) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 73 • HPN_Appeals Policy pg 9 • HPN_Rpt_Member Exp Appeals Closed • HPN_Appeal Rights pg 3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN does not have any examples during the audit period of 1/1/22-5/31/22.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the case file review and MCO staff members confirmed that all appeal decisions were made in a timely manner during the time period under review. **Recommendations:** HSAG recommends that the MCO develop an appeal resolution notice template to comply with notice requirements when appeals are not decided in a timely manner. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
26. For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal. 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228	**HSAG Recommended Evidence** • Policies and procedures • Appeal resolution notice templates (upheld and overturned) • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 7 • HPN_Appeal Overturn Letter • HPN_Appeal Denial Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO indicated that the appeal resolution notice mailing date is the date the resolution is completed, HSAG strongly recommends that the MCO consider populating the resolution complete date within the body of the resolution notice. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
27. For notice of a *standard* and expedited appeal resolution, the MCO is *required to make a good faith effort* to provide oral notice *of the disposition in addition to the required written notice*. 42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 7.8.10.11.1	**HSAG Recommended Evidence** • Policies and procedures • Three examples of oral notice for an expedited appeal resolution • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 7 • HPN_Rpt_Member Exp Appeals_Closed	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: According to the case file review, the MCO was not consistently notifying the member orally of the appeal resolution. For four cases, the member was only informed that a letter was being mailed, but the details of the resolution were not provided; for one case, the provider was notified of the resolution, but the member was not contacted; and for another case, no call attempts were made to notify the member orally of the resolution.		
Required Actions: For notice of a standard and expedited appeal resolution, the MCO must make a good faith effort to provide oral notice of the disposition of the appeal in addition to the required written notice.		
State Fair Hearings		
28. The member may request a SFH only after receiving notice that the MCO is upholding the ABD related to the appeal. 42 CFR §438.408(f)(1)(i) 42 CFR §438.228 Contract 7.8.10.6.2; 7.8.10.12.1	**HSAG Recommended Evidence** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 9 • HPN_Appeal Denial Letter • HPN_SFH Rights • HPN_ Appeal Rights pg 3	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element**.**		
Required Actions: None.		
29. *The member must submit a request for a SFH in writing within ninety (90) calendar days from the date of the MCO's notice of resolution of the appeal.* a. *The MCO is required to inform the member of their right to a SFH, how to obtain such a hearing, requirements for continuation of benefits, and representation rules must be explained and provided in writing to the member by the MCO pursuant to 42 CFR §431.200(b); 42 CFR §431.220(a)(6) and 42 CFR §438.408(e)(2)(i).* 42 CFR §438.408(f)(2) 42 CFR §438.228 Contract 7.8.10.12.1; 7.8.10.12.2	**HSAG Recommended Evidence** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 73 • HPN_Appeals Policy pg 9 • HPN_Appeal Denial Letter • HPN_Appeal Rights pg 3 • HPN_SFH Rights	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Continuation of Benefits		
30. The MCO must continue the member's benefits if all of the following occur a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. *Timely files* means on or before the later of the following within ten (10) calendar days of the MCO sending the notice of ABD, or the intended effective date of the MCO's proposed ABD. 42 CFR §438.420 (a-b) 42 CFR §438.228 Contract 7.8.10.8.1; 7.8.10.8.1.1-7.8.10.8.1.6	**HSAG Recommended Evidence** • Policies and procedures • ABD notice template • Appeal resolution notice template • Three examples of member requests for continuation of member benefits **Evidence as Submitted by the MCO** • HPN_Appeals Policy pgs 7-8 • HPN_Appeal Rights pg 3 • HPN_Appeal Denial Letter • HPN_ABD Notice Template	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
31. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs a. The member withdraws the appeal or request for SFH. b. The member fails to request a SFH and continuation of benefits within ten (10) calendar days after the MCO sends the notice of an adverse resolution to the member's appeal. c. A SFH office issues a hearing decision adverse to the member. 42 CFR §438.420 (c) 42 CFR §438.228 Contract 7.8.10.8.2; 7.8.10.8.2.1-7.8.10.8.2.3	**HSAG Recommended Evidence** • Policies and procedures • Three examples of documentation related to continuation of member benefits **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 8	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN does not have any examples of a member receiving continuation of benefits during the audit period of 1/1/22-5/31/22.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
32. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCO's ABD, the MCO may recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements of this section and in accordance with the policy set forth in 42 CFR §431.230(b). 42 CFR §438.420 (d) 42 CFR §438.228 Contract 7.8.10.8.3	**HSAG Recommended Evidence** • Policies and procedures • One example of cost recovery **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 8 • HPN_Appeal Rights pg 3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN does not have any examples of cost recovery during the audit period of 1/1/22-5/31/22.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
33. If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.424(a) 42 CFR §438.228 Contract 7.8.10.8.4	**HSAG Recommended Evidence** • Policies and procedures • Three examples of reinstatement of services (the date of the reversal and date the services were reinstated must be included) **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 9	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: HPN does not have any examples during the audit period of 1/1/22-5/31/22.		
HSAG Findings: Three cases reviewed as part of the case file review indicated that three appeals were overturned by the MCO. After the site review, the MCO provided documentation requested by HSAG to demonstrate that services were authorized or provided within 72 hours from the date the MCO determined that the denial of services were reversed. For one case, although the appeal decision was made on March 9, 2022, the authorization was not updated in the system until March 15, 2022, which was outside of the required 72 hours.		
Required Actions: If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		
34. If the MCO or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, *the MCO must pay for those services.* 42 CFR §438.424(b)	**HSAG Recommended Evidence** • Policies and procedures • Three examples of a SFH reversal with corresponding authorization of services **Evidence as Submitted by the MCO**	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.8.4	• HPN_Appeals Policy pg 9	
MCO Description of Process: HPN does not have any examples during the audit period of 1/1/22-5/31/22.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Grievances, Appeals, and State Fair Hearings		
35. In handling grievances and appeals, the MCO must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate teletypewriter (TTY)/telecommunications device for the deaf (TTD) and interpreter capability. a. *The MCO must assist the member and/or the member's representative to arrange for non-emergency transportation services to attend and be available to present evidence at the appeal hearing.* 42 CFR §438.406(a) 42 CFR §438.228 Contract 7.8.10.10.1	**HSAG Recommended Evidence** • Policies and procedures • Member handbook(s) • One example of assistance to members in filing a grievance and appeal **Evidence as Submitted by the MCO** • HPN_Member Handbook_G & A pg 2, 16, 73 • HPN_Appeals Policy pg 5 • HPN_Appeal Rights pg 1, 3	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
36. The MCO must provide information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.414 42 CFR §438.228 Contract 7.8.10.4; 7.8.10.4.1-7.8.10.4.5	**HSAG Recommended Evidence** • Policies and procedures • Provider manual • Provider contract template • Subcontractor agreement template **Evidence as Submitted by the MCO** • HPN_PCP Contract Template pg 25, 27, 28 • HPN_Provider Summary Guide Sections 8.8, 8.10 in whole	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
37. The MCO must include as parties to the appeal and SFH a. The member and his or her representative b. The legal representative of a deceased member's estate c. *The MCO will participate in the SFH process, at the MCO's expense, in each circumstance in which a member for whom the MCO has made an ABD requests a SFH. The MCO is bound by the decision of the Fair Hearing Officer.* 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §438.228 Contract 7.8.10.10.8; 7.8.10.12.3	**HSAG Recommended Evidence** • Policies and procedures • Evidence of SFH participation **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 6 • HPN_SFH Confirmation of Participation pg 1	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recordkeeping Requirements		
38. Grievance and appeal records must be accurately maintained *for a period of no less than ten (10) years* in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. 42 CFR § 438.416(b-c) 42 CFR §438.228 Contract 7.8.10.5.7	**HSAG Recommended Evidence** • Policies and procedures • HSAG will also use the results of the Appeals and Grievances File Reviews **Evidence as Submitted by the MCO** • HPN_Appeals Policy pg 10	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: a. - f. Will be demonstrated through the case file review.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems						
Met	=	33	X	1	=	33
Not Met	=	5	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	38	Total Score		=	33
Total Score ÷ Total Applicable					=	87%

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCO may have with any delegate, MCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. a. *The MCO must evaluate the prospective subcontractor's ability to perform the activities to be delegated.* b. *The MCO must submit all subcontractors to DHCFP for advance written approval prior to the subcontractor's effective date.* c. *Within thirty-five (35) calendar days of the date of request, the MCO must provide full and complete information about the ownership of any subcontractor with whom the MCO has had a business transaction totaling more than twenty-five thousand dollars ($25,000) during the twelve-month (12-month) period ending on the date of request as required by 42 CFR §455.105.* 42 CFR §438.230(b)(1) Contract 7.2.2.1; 7.2.2.2; 7.2.2.3; 7.2.2.4	**HSAG Recommended Evidence:** • Policies and procedures • Pre-delegation assessment (for delegates implemented within the past fiscal year) • Written approval from DHCFP (for delegates implemented within the past fiscal year) • Example of completed request for ownership information • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • HPN_WRHCO 338 Ownership Reporting pg 2 • HPN_WRHCO 352 Subcontract Requirements • HPN_DHCFP Approval – IHC delegation • HPN_OptumNV Preassessment Report • HPN_OptumRx_Pharmacy Delegated Entity Oversight Policy • HPN_OptumRx_Government Programs Pharmacy – Program Administration Overview • HPN_Cred-Recred Policy pgs 3, 25-29	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: HPN has not been requested to provide ownership information on any delegated entity.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO confirmed that it has not received a request for information about the ownership of any subcontractor from DHCFP. **Recommendations:** While not specific to this element, HSAG recommends that the MCO conduct a review of all subcontracts and written arrangements, and internal processes to ensure all delegation-related requirements are clearly delineated (e.g., contract provisions including reporting requirements, ongoing monitoring, formal review expectations) for each delegate specific to the Nevada Medicaid program. This is particularly important for pre-existing		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
sub-contractors which may require contract revisions due to new federal or state-specific requirements. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO determine that the delegate has not performed satisfactorily. 42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) Contract 7.2.2.5	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • HPN_WRHCO 352 Subcontract Requirements • HPN_WRCHO 345 Delegation of Responsibilities to Subcontractors • HPN_OptumRx_Agreement_Original pgs 3, 27 • HPN_OptumRx_Agreement_Amendment_IV pg 9	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, *including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention.* 42 CFR §438.230(c)(2) Contract 7.2.2.7	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • HPN_EyeMed Contract Exhibit C (Bookmarks) • HPN_WRHCO 352 Subcontract Requirements • HPN_OptumRx_Agreement_Original pgs 1, 4, 13, 16	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: While a memorandum of understanding (MOU) between the MCO and one of its delegates, responsible for performance credentialing functions on behalf of the MCO, included a provision requiring the delegate to comply with all State and federal credentialing requirements, the MOU did not specifically require the delegate to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention as required by the MCO's contract with DHCFP. MCO staff members explained that there is a base agreement to the MOU. However, after the site review, the MCO indicated that the MOU is the MCO's standard procedure between internal business segments and confirmed there was no base agreement or additional documentation to submit. However, as the entity is performing delegated credentialing functions on behalf of the MCO, the MCO's written arrangements must comply with 42 CFR §438.230 and the MCO's contract with DHCFP.		
Required Actions: The MCO must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention.		
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records,	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • HPN_EyeMed Contract Exhibit C (Bookmarks)	☐ Met ☒ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3)(i-iv)	• HPN_WRHCO 345 Delegation of Responsibilities to Subcontrators • HPN_OptumRx_Agreement_Original (page 9)	
MCO Description of Process:		
HSAG Findings: The MOU between the MCO and one of its delegates did not include the requirements of this element. MCO staff members explained that there is a base agreement to the MOU. However, after the site review, the MCO indicated that the MOU is the MCO's standard procedure between internal business segments and confirmed there was no base agreement or additional documentation to submit. However, as the entity is performing delegated credentialing functions on behalf of the MCO, the MCO's written arrangements must comply with 42 CFR §438.230 and the MCO's contract with DHCFP. Additionally, while the Statement of Work (SOW) for one of the MCO's delegates included the requirements of sub-elements (a) and (b), the requirements of sub-elements (c) and (d) were not located. The SOW did identify suspected Medicaid fraud as a means that would warrant an audit but stipulated that the delegate is subject to an audit during regular business hours, at various but necessary times by DHCFP, the examiner, or designee. However, the MCO must clarify that an audit may occur due to suspected fraud at any time. The time period for the right to audit (i.e., sub-element [c]) was not located in the SOW. After the site review, the MCO submitted the original Master Services Agreement (MSA) and explained that SOW No. 6, when		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Medicaid was included in the contract, states that all requirements in the MSA pertain to the SOW; and while the original SOW does not mention Medicaid, the SOW No. 6 incorporating Medicaid states that the MSA applies. However, while the MSA may apply, the language that meets the requirements of sub-element (c) and (d) is located under a Medicare addendum to the MSA. The MCO should have updated its MSA and/or SOW, and/or a Medicaid addendum when the Medicaid managed care regulations were updated in 2016 and required this specific language to be included in all Medicaid delegated written arrangements or contracts.		
Required Actions: The MCO must ensure that all contracts or written arrangements indicate, and the delegate agrees that: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. • The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. • The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.		
Monitoring and Auditing		
5. *The MCO is responsible for oversight of all subcontracts and is accountable for any responsibilities it delegates to any subcontractor.* a. *The MCO must monitor the subcontractor's performance on an on-going basis.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of consecutive reporting • Three examples of consecutive delegation oversight committee meeting minutes • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • HPN_EyeMed Contract Exhibit C (Bookmarks) • HPN_WRHCO 345 Monitoring Performance of a Subcontractor • HPN_OptumRx_PBM_Metrics_May_2022	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• HPN_OptumRx_cPAC_Committee_Agenda_Minutes_May_2022 • HPN_Alorica QBR 2022_Q1 • HPN_Alorica SampleMetricQTD	
MCO Description of Process: Consecutive reporting examples are not available due to the short audit period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. *The MCO conducts a formal review of the subcontractor according to a periodic schedule established by the State, consistent with industry standards, and/or State laws and regulations.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of formal review results • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • HPN_OptumRx_Q1 2022 Performance Oversight Summary • HPN_EyeMed Audit Results • HPN_Alorica QBR 2022_Q1	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The quarterly Committee meeting only occurred once during the audit period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. *If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of corrective action plans • Committee meeting minutes • HSAG will use the results from the Delegation File Review	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCO: • HPN_OptumRx_Business Improvement Requests Procedure • HPN_OptumRx_Corrections Process Policy • HPN_OptumRx_Corrective_Action_Plan_May_2022 • HPN_OptumRx_cPAC_Committee_Agenda_Minutes_May_2022 • HPN_OptumRx Regional Team Projects Issues Log May 2022	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation						
Met	=	5	X	1	=	5
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	Total Score		=	5
Total Score ÷ Total Applicable					=	71%

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. *The MCO's Chief Medical Director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.* Contract 7.2.1.6.2.3	**HSAG Recommended Evidence:** • Job description • Committee charter • Committee meeting minutes **Evidence as Submitted by the MCO:** • HPN_NMCMC Minutes 2-14-22, pg 5 • HPN_NMCMC Charter 2022, entire document	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review and include attendance by HPN's CMO.		
HSAG Findings: The National Medical Care Management Committee (NMCMC) is responsible for the review of clinical policies, criteria, and guidelines recommended by the Medical Technology Assessment Committee (MTAC) and/or other appropriate committee, for all UnitedHealthcare plans. The MCO's chief medical officer (CMO) attends NMCMC meetings but is not a voting member. MCO staff members explained during the site review that although the MCO's CMO is not a voting member of the NMCMC, a NMCMC committee member is not prohibited from bringing items to the committee for discussion. While the MCO appears to be adopting all clinical care standards, practice guidelines, and protocols approved by the NMCMC, there was no local health plan-level process led by the MCO's CMO to adopt clinical care standards, practice guidelines, and protocols that specifically relate to the Nevada Medicaid program and the members served.		
Required Actions: The MCO must ensure that the MCO's chief medical director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.		
2. The MCO must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236 (b)(1) Contract 7.6.12.1; 7.6.12.1.1	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• HPN_NMCMC Minutes 2-14-22, pg 5 • Medical & Drug Policies and Coverage Determination Guidelines for Community Plan | UHCprovider.com	
MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review. The web link above allows providers to access and search for clinical guidelines.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
3. The MCO must adopt practice guidelines that consider the needs of the MCO's members. 42 CFR §438.236 (b)(2) Contract 7.6.12.1.2	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** • HPN_NMCMC Minutes 2-14-22, pg 5 • Medical & Drug Policies and Coverage Determination Guidelines for Community Plan | UHCprovider.com	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review. The web link above allows providers to access and search for clinical guidelines.		
HSAG Findings: While the MCO appears to be adopting all clinical care standards, practice guidelines, and protocols approved by the NMCMC, there was no local health plan-level process led by the MCO's CMO to adopt clinical care standards, practice guidelines, and protocols that specifically relate to the Nevada Medicaid program and the members served. Although the UnitedHealthcare *Community Plan Medical & Drug Policies and Coverage Determination Guidelines* indicated specific states in which the overarching medical policy library did not apply, Nevada was not included as one of these states.		
Required Actions: The MCO must adopt practice guidelines that consider the needs of the MCO's members.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
4. The MCO must adopt practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236 (b)(3) Contract 7.6.12.1.3	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval • Evidence of consultation of network providers **Evidence as Submitted by the MCO:** • HPN_NMCMC Minutes 2-14-22, pg 5 • HPN_Clinical Guideline Example, entire document • Medical & Drug Policies and Coverage Determination Guidelines for Community Plan | UHCprovider.com • HPN_BH UM Program Description pg 17-18	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review. A sample practice guideline is submitted as well.		
HSAG Findings: Although the Behavioral Health Utilization Management Program Description indicated that clinical criteria were being reviewed by the Behavioral Health Utilization Management Subcommittee, the charter included as part of the program description did not support that Nevada Medicaid contracted providers were committee members. Additionally, no additional evidence was provided to support that Nevada Medicaid contracted providers were consulted by the NMCMC when adopting practice guidelines.		
Required Actions: The MCO must adopt practice guidelines that are adopted in consultation with network providers.		
5. The MCO must adopt practice guidelines that are reviewed and updated periodically as appropriate. 42 CFR §438.236 (b)(4) Contract 7.6.12.1.4	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Meeting minutes documenting committee review/approval **Evidence as Submitted by the MCO:** • HPN_MCG Annual Update screenshot 3-2022	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• Medical & Drug Policies and Coverage Determination Guidelines for Community Plan | UHCprovider.com	
MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element as evidence was provided to support that the NMCMC reviewed guidelines annually. Please refer to the findings in Element 1 of this standard as the guidelines should be reviewed and updated periodically by local MCO staff members, including the MCO's CMO, committee members, and Nevada Medicaid contracted providers.		
Required Actions: None.		
6. *The MCO must adopt practice guidelines that comply with requirements for parity in mental health and substance use disorder benefits in accordance with 42 CFR §438.910(d).* a. *The MCO's prior authorization requirements are documented and applied in a manner that comply with the guidelines for parity in mental health and substance use disorder.* Contract 7.6.12.1.5	**HSAG Recommended Evidence:** • Policies and procedures • List of adopted practice guidelines • Utilization review program description • Meeting minutes documenting committee review/approval • Prior authorization criteria for mental health/substance use disorder treatment **Evidence as Submitted by the MCO:** • HPN_Mental Health and Substance Abuse Benefits, highlights throughout • HPN_BH UM Program Description pgs. 17-18, 24 • HPN_Authorization Criteria NQTL, whole document • HPN_Parity Auth Crosswalk	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Dissemination of Guidelines		
7. The MCO disseminates the guidelines, *including prior authorization policies and procedures*, to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236 (c) Contract 7.6.12.2	**HSAG Recommended Evidence:** • Policies and procedures • Utilization review program description • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCO:** • HPN_Provider Summary Guide_Std XII sec 8.9. pg 6 • Medical Policies - Doctor / Provider - Health Plan of Nevada • Prior Authorizations – Doctor / Provider – HPN Medicaid • HPN_Nevada Medicaid and Check Up Handbook, pg 28	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Application of Guidelines		
8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236 (d) Contract 7.6.12.3	**HSAG Recommended Evidence:** • Policies and procedures • Coverage guidelines/criteria • Utilization review program description • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters)	☒ Met ☐ Not Met ☐ NA

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• Three examples of coverage denial notices	
	Evidence as Submitted by the MCO: • HPN_Spring 2022 HealthTALK Magazine, pgs 6, 10, 11 • HPN_Nevada Medicaid and Check Up Handbook, pg 17, 38, 59 • Coverage and Benefits – Member – HPN Medicaid • Disease Management – Member – HPN Medicaid • HPN_PA Denial 1 • HPN_PA Denial 2 • HPN_PA Denial 3 • HPN_PA Review Process • HPN_2022 UMPD NV Addendum pg 8, 16	
MCO Description of Process: Links provided to member education of benefits and services pages on MyHPNMedicaid.com		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
9. *Network providers are required to use designated practice guidelines and protocols.* Contract 7.6.12.4	**HSAG Recommended Evidence:** • Policies and procedures • Provider materials, such as provider manual • Provider contract template • Utilization review program description	☒ Met ☐ Not Met ☐ NA
	Evidence as Submitted by the MCO: • HPN_Network Participation Standards pg 1 • HPN_Provider Summary Guide_Std XII sec 8.11, pg 9-10 • HPN_BH UM Program Description pg 17-18	

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. *The MCO offers feedback to individual network providers on adherence to evidence-based practice guidelines and positive and negative care variances from standard clinical pathways that may impact outcomes or costs.* a. *The MCO uses this information to guide activities, such as performance improvement projects for network providers.* Contract 7.6.9	**HSAG Recommended Evidence:** • Policies and procedures • Utilization review program description • Three examples of provider education re: adherence to practice guidelines • Analyses of information, and documentation of follow-up activities **Evidence as Submitted by the MCO:** • HPN_HCA JOC Minutes 01-26-2022 • HPN_WHASN JOC Minutes 01-20-2022 • HPN_NKDHC JOC Minutes 04-05-2022 • HPN_2022 UMPD NV Addendum pg 16 • HPN_PBS Anesthesia Education Letter • HPN_Good Shepherd Education Letter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XII—Practice Guidelines						
Met	=	7	X	1	=	7
Not Met	=	3	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	10	Total Score		=	7
Total Score ÷ Total Applicable					=	70%

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems must provide information on areas including, but not limited to: a. Utilization b. Claims payment c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility e. *Enrollment* f. *Eligibility* g. *Provider network data* h. *Encounter data* i. *Electronic Visit Verification (EVV)* 42 CFR §438.242(a) Contract 7.12.2.1; 7.12.2.2; 7.12.4.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current Information Systems Capabilities Assessment (ISCA) • Technical manual(s) • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** • All documents below provide evidence on our Health Information System and should be used, along with the demonstration of our systems, as evidence for this Requirement.	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG requested screen shots of the MCO's system to confirm it had the capability to document the reason for disenrollment as provided by DHCFP on the enrollment and eligibility file. After the site review, a screen shot of a "Reason" displayed as "T090 Per tape/file transmit/dwnload" was provided. As this did not appear to be an actual reason for a disenrollment (e.g., 03 Death, 07 Termination of Benefits), HSAG requested further clarification; however, the MCO confirmed it had no additional documentation to submit.		
Required Actions: The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements, including the reason for member disenrollment as provided by DHCFP.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of a Health Information System		
2. The MCO must comply with section 6504(a) of the Affordable Care Act, and ensure its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by DHCFP to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) Contract 7.7.1.3	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** • HPN_WRHCO 277 Medicaid Encounter Reporting • HPN_Medicaid Claims Processing (Medical) • HPN_Medicaid Claims Processing (Dental and Vision) • HPN_Medicaid Claims Reconsideration Processing • HPN_Provider Summary Guide_Claims Section 13.8, 13.10	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
3. The MCO shall comply with the following: a. The MCO must collect data on member and provider characteristics as specified by DHCFP and on all services furnished to members through an encounter data system or other method as may be specified by DHCFP. 42 CFR §438.242(b)(2) Contract 7.12.4.1.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** • HPN_WRHCO 277 Medicaid Encounter Reporting • HPN_Edifecs EM Workflow	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• HPN_ECF_Extract_TechSpec • HPN_EM_Baseline_Mapping • HPN_Provider Summary Guide_Claims Section 13.10 • HPN_Rx Encounter Policy & Procedure_UHC	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. The MCO must ensure that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCO is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) Contract 7.12.4.1.2-7.12.4.1.3	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** • HPN_WRHCO 277 Medicaid Encounter Reporting • HPN_Provider Summary Guide_Claims whole document • HPN_Medicaid Claims Processing (Medical) • HPN_Medicaid Claims Processing (Dental and Vision) • HPN_Medicaid Claims Reconsideration Processing • HPN_Medicaid Clean Claim Report • HPN_Claims Processing Flow	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
5. The MCO must make all collected data *outlined in the Contract, DHCFP's electronic MoveIt reporting repository, or any successor repository, attachments, and guidance* available to the DHCFP and upon request to CMS. 42 CFR § 438.242(b)(4) Contract 7.12.4.1.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements/reports • Encounter data acceptance/rejection reports **Evidence as Submitted by the MCO:** • HPN_Department Dashboard Summaries • HPN_Edifecs Monitoring • HPN_ECG Transfers • HPN_Encounters Dashboard	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Member Eligibility Database		
6. *The MCO's enrollment system is capable of linking records for the same member that are associated with different Medicaid and/or Nevada Check Up identification numbers (e.g., members who are re-enrolled and assigned new identification numbers).* Contract 7.12.3.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • HPN_Facets_member_Lookup_technical_specification • HPN_FacetsMemberLookup	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: From a system perspective our enrollment system recognizes someone as already existing in the system by performing a "Facets Member Look Up".		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Application Programming Interface		
7. The MCO must implement an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCO. Information must be made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed; b. Encounter data no later than one (1) business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one (1) business day after the data is received by the MCO; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one (1) business day after the	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • API project plan(s) • API documentation • HSAG will use the results from the API demonstration **Evidence as Submitted by the MCO:** • HPN_Facets Open Access Solution Guide, whole document	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 Contract 7.12.6; 7.12.6.1.1-7.12.6.1.4		
MCO Description of Process: The Facets API is software provided by the Facets vendor (Cognizant). It is included when you install Facets on an application server computer. The API gives programmers a way to work with the Facets database programmatically, without the use of the Facets front-end user interface. Here is the document that tells programmers how to use the API (once installed on a server): Facets_Open_Access_Solution_Guide_5.90.pdf (sierrahealth.com)		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
8. The MCO must maintain a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which must include all information specified in 42 CFR §438.10(h)(1) and (2). 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) Contract 7.8.8.3-7.8.8.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Link to web-based provider directory(ies) • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the MCO:** • Find a Doctor / Provider - Member - Home (myhpnmedicaid.com) • HPN_Online Directory Policy • HPN_Provider Directory Scheduling and Process	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Member Encounter Data		
9. The MCO must collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) Contract 7.12.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** • HPN_Edifecs EM Workflow • HPN_ECF_extract_TechSpec • HPN_EM_Baseline_Mapping • HPN_Claims Processing Flow • HPN_Claims Transition Report Example • HPN_Provider Summary Guide_Claims whole document	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. The MCO must submit member encounter data to DHCFP *within ninety (90) calendar days of receipt of the encounter and in the appropriate CMS-1500 and UB-04 format or an alternative format if prior approved by DHCFP,* based on program administration, oversight, and program integrity needs. a. The member encounter data must include all DHCFP-specific requirements for encounter data submissions, including allowed amount and paid amount, that DHCFP is required to report to CMS under 42 CFR §438.818.	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent encounter submissions compliance reports (acceptance/rejection reports) • Excerpts of encounter data files for professional, institutional, and pharmacy **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
b. The member encounter data must be submitted to DHCFP in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. 42 CFR §438.242(c)(2-4) Contract 7.12.4.2-7.12.4.8	• HPN_WRHCO 277 Medicaid Encounter Reporting • HPN_Rx Encounter Policy & Procedure_UHC pg 3 • HPN_NCPDP_RX_Response File • HPN_NCPDP_RX_Submission File	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The MCO is required by its contract with DHCFP to pay 99 percent of all clean claims within 90 calendar days of the date of receipt and also submit encounter data to DHCFP within 90 calendar days of receipt of the claim. Therefore, if the MCO paid/denied a clean claim on day 90, the encounter data would need to be submitted to DHCFP that same day to be compliant with the 90-calendar-day time frame for encounter data submissions. Depending on when the encounter data are submitted to DHCFP, the MCO theoretically could be out of compliance with the 90-calendar-day time frame for encounter data submission but still be compliant with the 90-calendar-day time frame for paying/denying clean claims. As such, HSAG recommends that the MCO consult with DHCFP to obtain clarification on the expectations for submitting encounter data to DHCFP within 90 calendar days of receipt of the claim when the contract also allows the MCO 90 calendar days to pay/deny a clean claim within 90 calendar days of receipt of the claim. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Claims Payment		
11. *The MCO has written policies and procedures for processing claims submitted for payment from any source and shall monitor its compliance with these procedures.* Contract 7.7.1.5-7.7.1.7	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Claims processing guidelines • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • HPN_WRHCO 277 Medicaid Encounter Reporting • HPN_Provider Summary Guide_Claims whole document	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• HPN_Medicaid Claims Processing (Medical) • HPN_Medicaid Claims Processing (Dental and Vision) • HPN_Medicaid Claims Reconsideration Processing	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Information Technology System for Care Management Programs		
12. *The MCO's information technology system for its Care Management program maximizes the opportunity for communication between the MCO, PCP, the member, other service providers, and case managers.* Contract 7.5.6.8.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • HPN_ICM User Guide: pages 111 Section 6, and pg 155 Section 9 • HPN_Claims Transition Report Example	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. *The MCO has an integrated database that allows MCO staff that may be contacted by a member in Case Management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case,*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:**	☐ Met ☒ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
including the MCO's 24-hour Nurse Line. The integrated database must include all of the following: a. *Administrative data* b. *Call center communications (contact tracking)* c. *Service authorizations* d. *HL7 inpatient and ER notifications* e. *Person centered care treatment plans* f. *Patient assessments* g. *Case management notes* Contract 7.5.6.8.2; 7.5.6.8.4	• HPN_ICM User Guide: pages 47 Figure 3-9, pg 56 Section 4.1, pg 103 Section 5.5, and pg 133 Section 7.1 • HPN_Claims Transition Report Example	
MCO Description of Process:		
HSAG Findings: While the care managers could review member calls via a dashboard, only the "Reason" (e.g., "13/Dentist," "13/Prov Info") for the call was viewable, and the call notes were not pulled into the dashboard. After the site review, the MCO explained that the topic of the calls is generally enough to understand that the member has called the health plan and the care manager can discuss outstanding issues with the member; however, the call communications were not available to care management staff. MCO staff also explained they are working to ensure that care management staff members' permissions are current (e.g., access to the call center system).		
Required Actions: The MCO must have an integrated database that allows MCO staff who may be contacted by a member in care management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case, including call center communications.		
Electronic Visit Verification		
14. *The MCO implements the State's contracted Electronic Visit Verification (EVV) system for the following services:* a. *Personal Care Services, upon the Contract go-live date.* b. *Home Health Services, no later than January 1, 2023.* c. *Any additional services identified by DHCFP.*	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Contract 7.12.7	• HPN_EVV_Example_1 • HPN_EVV_Example_2 • HPN_DME PA-12 Personal Care Assistance SOP	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, sub-element (b) was not applicable to the time period of review.		
Required Actions: None.		

Standard XIII—Health Information Systems						
Met	=	12	X	1	=	12
Not Met	=	2	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	14	**Total Score**		=	12
Total Score ÷ Total Applicable					=	86%

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program (*referred to as the Internal Quality Assurance Program [IQAP] in Nevada*) for the services it furnishes to its members. a. *The QAPI program consists of systematic activities, undertaken by the MCO, to monitor and evaluate the care delivered to members according to predetermined, objective standards, and effect improvements as needed.* 42 CFR §438.330(a)(1) Contract 7.9.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, entire document • HPN_2022 Medicaid QI Workplan, entire document	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
2. *The MCO must submit a QAPI program description and progress report using the template required by DHCFP by March 30 annually. The program description must:* a. *Encompass all levels of the MCO's organization.* b. *Have a clear linkage to DHCFP's Quality Strategy.* Contract 7.9.2.5	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Evidence of QAPI program submission to DHCFP **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 23 • HPN_2022 Medicaid QI Workplan, entire document	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of QAPI Programs		
3. *The written QAPI program description must contain a detailed set of quality assurance objectives that are developed annually and include a timetable for implementation and accomplishment.* Contract 7.9.3.1.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, Pg 9 • HPN_2022 Medicaid QI Workplan, Pgs 1-5	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Part I of the Medicaid QI Workplan (pages 1-5) includes a detailed set of QA objectives that are reviewed and updated annually. Measures of focus are determined by the state and accreditation guidelines.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. *The scope of the QAPI program is comprehensive, addressing both the quality of clinical care and the quality of non-clinical aspects of service.* a. *The scope includes availability, accessibility, coordination, and continuity of care.* Contract 7.9.3.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, Pgs 5-6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
5. *The written QAPI program description provides for continuous performance of the activities, including tracking of issues over time.* Contract 7.9.3.4	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 27 • HPN_2022 Medicaid QI Workplan, pgs 6-10	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Parts II and III of the QI Workplan contain continuous monitoring and reporting requirements for both quality of service and quality of care elements.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
6. The QAPI program must include mechanisms to assess both underutilization and overutilization of services *and appropriate follow up.* a. *If fraud and abuse is suspected, a referral was made to the MCO's program integrity unit and DHCFP Surveillance and Utilization Review (SUR) Unit for appropriate action.* 42 CFR §438.330(b)(3) Contract 7.9.4.5.4	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • Evidence demonstrating assessment of underutilization and overutilization of services (e.g., committee meeting minutes, reports) • Evidence of underutilization and overutilization of services follow-up actions **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 5 • HPN_UMC Minutes 4.21.22, pg 4	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The Utilization Management Committee (subcommittee of the Quality Improvement Committee) monitors two medical and two behavioral Healthcare Effectiveness Data and Information Set (HEDIS®)[A-1] measures for under and over utilization of services. Interventions in place to improve utilization in those measures that report as underutilized are discussed. Overutilization, if discovered, is reported to the SUR Unit.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. The QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by DHCFP in the Quality Strategy. a. *The QAPI program methodology must provide for review of the entire range of care provided by the MCO, including services provided to Children with Special Health Care Needs (CSHCN), by assuring that all demographic groups, care settings (e.g., inpatient, ambulatory, including care provided in private practice offices and home care); and types of services (e.g., preventive, primary, specialty care, and ancillary) are included in the scope of the review.* b. *The review of the entire range of care must be carried out over multiple review periods and not on a concurrent basis.* c. *This review occurs no less than annually.* 42 CFR §438.330(b)(4) Contract 7.9.3.2.2	**HSAG Recommended Evidence:** • QAPI program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 5 • HPN_2021 Medicaid QIPE, pg 3, 7-20, 20-29, 44-46,	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: CSHCN are included in our pediatric care management program as well as gaps in care reports that are hand-delivered monthly to pediatricians. We have bookmarked both pediatric and adult HEDIS measures indicating services delivered in multiple care settings over multiple review periods. Additionally, we perform focused analysis of accessibility, including an evaluation of oncology as a high impact specialty.		

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

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While the MCO's 2022 Medicaid Quality Program Description identified that coordination of healthcare services for CSHCN Medicaid and Nevada Check Up members would be monitored and reported, HSAG recommends that the MCO enhance its QAPI program description to include additional detail as to the specific monitoring and reporting activities planned for this population and incorporate the results of the monitoring activities into the annual QAPI program evaluation. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
8. The QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i) Contract 7.9.3.2.3	**HSAG Recommended Evidence:** • QAPI program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Audit tools and results **Evidence as Submitted by the MCO:** • HPN_COC Policy – 2021, entire document • HPN_Medical Continuity and Coordination of Care 2021, entire document (bookmarks are present to indicate each of the seven programs analyzed)	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Please see the COC policy and report, HPN_Medical Continuity and Coordination of Care 2021, for multiple examples of programs developed specifically to focus our resources on patient groups who need us the most. The Care for Me Program is specific for members recently discharged from the hospital. This program ensures the member has what they need immediately after discharge and reduces the readmission rate. Other programs such as the Community Health Worker Program, Sickle Cell Disease Outreach Program, etc. are excellent examples of assessing care across various settings (inpatient, home, ER, SNF).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. While the MCO does not manage the benefits for waiver members, HSAG has determined that this element is applicable as the MCO is responsible for providing LTSS (e.g., personal care services) to its members as medically necessary.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Adequate Resources		
9. *The QAPI program must have sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.* a. *The MCO dedicates sufficient staff to fulfill the MCO's set of clearly defined functions and responsibilities, so that staffing is proportionate to and adequate for the planned number of and types of quality improvement (QI) initiatives within the managed care program.* b. *A QI Manager is dedicated to the managed care program with reporting authority to the MCO's medical director.* Contract 7.9.4.13; 7.9.4.13.1	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job descriptions • Training materials **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 17-18 • HPN_QI_Pop Health Org Chart, entire document • HPN_Job Descr_Dir Clin Qlty – entire document	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Quality Improvement department (org chart submitted) is comprised of various functional teams; some dedicated to the Medicaid population. Neydis Vanegas, C&S Director of Clinical Quality is the QI Manager dedicated to the Medicaid managed care program. She meets regularly with the C&S CMO, Rutu Ezhuthachan.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
10. *The MCO must have QI teams composed of MCO staff fully dedicated to the managed care program that represent the following areas of expertise:* a. *Continuous quality improvement.* b. *Analytics.*	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 17 • HPN_QI_Pop Health Org Chart, entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
c. *Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts.* d. *Health equity.* e. *The MCO's policies and processes related to the improvement topic.* f. *Member and provider perspectives (may be staff or liaisons with the MCO's member and provider services departments).* Contract 7.9.4.13.2; 7.9.4.13.2.1-7.9.4.13.2.6		
MCO Description of Process: The Quality Improvement department (org chart submitted) is comprised of various functional teams; some entirely dedicated to the Medicaid population (i.e., HROB, CHW programs). Neydis Vanegas, C&S Director of Clinical Quality is the QI Manager dedicated to the Medicaid managed care program. She meets regularly with the C&S CMO, Rutu Ezhuthachan, and there is a direct reporting line to the CMO's office. There is a fully staffed analytics team, with seasoned leadership and approximately 25 nurses as well as other licensed clinicians who provide extensive clinical experience that is applied to the plan's improvement efforts. An Associate Director of Health Equity was added to QI to address projects specific to health equity and the expansion of targeted programs for disparate populations. Clinical Practice Consultants, who report to the C&S Director of Clinical Quality, are field-based RNs who solicit provider perspectives on a daily basis. This feedback is considered when designing a simple report or a complex program. Last, the QI department works closely with both Provider Services and Member Services to ensure member and provider perspectives are accounted for in our program design. In 2022, the Provider Advisory Board and the Member Advisory Board were established in part to collect these perspectives.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Quality Assurance Committee		
11. *At a minimum, the MCO's quality committee structure must include the following committees:* a. *Executive Committee* b. *Quality Management Committee that reports to the Executive Committee* c. *Utilization Management (UM) Subcommittee that reports to the Quality Management Committee* d. *Care Management Subcommittee that reports to the Quality Management Committee* e. *Member Services Subcommittee that reports to the Quality Management Committee* f. *Member Advisory Board that reports to the Quality Management Committee* g. *Provider Services Subcommittee that reports to the Quality Management Committee* h. *Provider Advisory Board that reports to the Quality Management Committee* Contract 7.9.4.11.1; 7.9.4.11.1.1-7.9.4.11.1.8	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO include additional detail (e.g., enhanced description, committee charter) for all subcommittees and advisory boards that report up through the MCO's quality program and structure. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
12. *The structure/committee meets on a regular basis with a specified frequency, no less than quarterly to oversee QAPI program activities.* a. *This frequency is sufficient to demonstrate that the structure/committee is following up on all findings and required actions.* Contract 7.9.4.11.2	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • All committee charters under the structure • Three consecutive committee meeting minutes for each committee under the structure **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31 • HPN_PAB Meeting Notes, entire document • HPN_QIC 03-2022 Minutes, pg 2 • HPN_MAC Q1 minutes, entire document	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The QI Program Description reflects the committee structure from the Board of Directors to the QI subcommittees. Committee meetings ensued in Q2 therefore, there was insufficient time to hold 3 meetings each for the seven committees required between January and May (the audit timeframe). Committee meetings are currently set to quarterly, with reporting at the quarterly QIC. In 2022, the second QIC was held on June 13.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
13. *There is active participation in the QAPI committee from network providers, who are representative of the composition of the MCO's network.* a. *The MCO includes providers on, at a minimum, the UM and Provider Services Subcommittees.* Contract 7.9.4.11.6; 7.9.4.14.4	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • All committee charters under the structure, with a list of providers who serve on the QAPI committee(s) • Three consecutive committee meeting minutes for each committee under the structure **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• HPN_CAHTF Minutes March 2022, entire document • HPN_WHTF Minutes March 2022, entire document	
MCO Description of Process: The QI Program Description reflects the committee structure from the Board of Directors to the QI subcommittees. Committee meetings ensued in Q2 therefore, there was insufficient time to hold 3 meetings each for the seven committees required between January and May (the audit timeframe). Committee meetings are currently set to quarterly, with reporting at the quarterly QIC. In 2022, the second QIC was held on June 13. Please see "CAHTF Minutes March 2022", and "WHTF Minutes March 2022", subcommittees of the Quality Improvement Committee (QIC), that each reflect two network providers in attendance.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG strongly recommends that the MCO include in committee meeting minutes the provider organization affiliation when network providers attend and participate in committee meetings. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
14. *The Provider Advisory Board has broad representation of Provider types in the Network, including at least:* a. *One (1) PCP serving children and adolescents;* b. *One (1) PCP serving adults;* c. *One (1) OB/GYN;* d. *One (1) psychiatrist;* e. *One (1) licensed Behavioral Health clinical professional;* f. *One (1) substance abuse professional;* g. *One (1) community-based Care Coordinator or community Case Manager serving a Network Provider;* h. *One (1) peer support specialist or a Behavioral Health Case Manager; and* i. *Other practitioners, such that there is broad representation from across the geographic service area under the Contract.* Contract 7.9.4.14.6	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Provider Advisory Board charter, including a listing of provider names and specialties who serve on the Provider Advisory Board • Three consecutive committee meeting minutes for the Provider Advisory Board **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31 • HPN_PAB Meeting Notes, entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Committee meetings ensued in Q2 therefore, there was insufficient time to hold 3 meetings for this committee prior to May 31. Committee meetings are currently set to quarterly, with reporting at the quarterly QIC and the Provider Advisory Board will rotate between Las Vegas and Reno.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO received a *Met* score for this element as the MCO has been actively recruiting network providers to serve on its Provider Advisory Board. Additionally, due to the shortened review period, only one quarterly meeting occurred during the time period under review. **Recommendations:** HSAG strongly recommends that the MCO have strategies in place to ensure the MCO has and continues to have broad representation of network providers who actively participate on the Provider Advisory Board to maintain compliance with the requirements for this element. The MCO's implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
15. *The Provider Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.* Contract 7.9.4.14.7	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Provider Advisory Board charter • Three consecutive committee meeting minutes for the Provider Advisory Board • Evidence of submission of each set of minutes to DHCFP **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31 • HPN_PAB Meeting Notes, entire document • HPN_Submission of PAB Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Committee meetings ensued in Q2 therefore, there was insufficient time to hold 3 meetings for this committee prior to May 31. Committee meetings are currently set to quarterly, with reporting at the quarterly QIC and the Provider Advisory Board will rotate between Las Vegas and Reno.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
16. *The MCO develops a Member Advisory Board comprised of a minimum of twelve (12) members or members' designated legal representatives from across the geographic service area under the Contract.* Contract 7.9.4.15.4	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Member Advisory Board charter, including a listing of all members who serve on the Member Advisory Board • Three consecutive committee meeting minutes for the Member Advisory Board **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31 • HPN_Submission of MAC Minutes • HPN_MAC Q1 Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Committee meetings ensued in Q2 therefore, there was insufficient time to hold 3 meetings for this committee prior to May 31. Committee meetings are currently set to quarterly, with reporting at the quarterly QIC. The first Member Advisory Board was held on March 18 and 20 members attended. The second meeting was held in June (outside the audit period).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
17. *The Member Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.* Contract 7.9.4.15.5	**HSAG Recommended Evidence:** • QAPI program description • Quality committee structure • Member Advisory Board charter • Three consecutive committee meeting minutes for the Member Advisory Board • Evidence of submission of each set of minutes to DHCFP **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	• HPN_Submission of MAC Minutes • HPN_MAC Q1 Minutes	
MCO Description of Process: There is insufficient time in the audit period for three meetings. Committee meetings are currently set to quarterly, with reporting at the quarterly QIC. The first Member Advisory Board was held on March 18 and over 20 members attended. The second meeting was held in June (outside the audit period).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
18. *The MCO develops methods to encourage and ensure adequate member participation in the quarterly Member Advisory Board meetings, including but not limited to:* a. *Accommodating virtual participation* b. *Providing meeting materials ahead of time* c. *Providing meeting materials in literacy level appropriate for participants* d. *Arranging transportation when appropriate* e. *Providing childcare when appropriate.* Contract 7.9.4.15.6	**HSAG Recommended Evidence:** • QAPI program description • Three consecutive committee meeting minutes for the Member Advisory Board • Processes to encourage and ensure member participation **Evidence as Submitted by the MCO:** • HPN_MAC Q1 Minutes • HPN_2022 Medicaid QIPD, pg 11, 12, 15, 31	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The meeting was held virtually and over 25 members participated in the meeting. As we would normally serve lunch at such an event, and this was held virtually, we provided each participant with a subway gift card to purchase a lunch. The Q2 meeting was held on June 13, outside of the audit period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Performance Measurement		
19. The QAPI program must include the collection and submission of performance measurement data. The MCO must annually: a. Measure and report to DHCFP on its performance, using the standard measures required by DHCFP; b. Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP; or c. Perform a combination of the activities described in sub-elements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) Contract 7.9.2.9-7.9.2.9.10	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Performance measures reports • Evidence of submission of performance measurement reports to DHCFP (e.g., HEDIS Final Audit Report) **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 10 • HPN_2022 Medicaid QI Workplan, pg 6 • HPN_HSAG_FinalAuditReport pg 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Performance Improvement Projects		
20. The QAPI program must include performance improvement projects (PIPs). a. *The MCO annually conducts and reports on a minimum of three (3) clinical PIPs and three (3) non-clinical PIPs.* i. *The MCO participates in one (1) statewide PIP focusing on reduction in African American maternal and infant morbidity and mortality as defined by DHCFP.*	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 22	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
ii. *The MCO selects an additional two (2) projects from the list below, to serve as the MCO's required PIPs in accordance with 42 CFR §438.330(a)(2) and 42 CFR §438.358:* 1. *Increasing access to and use of primary care and preventive services across the covered population.* 2. *Improving quality of and access to Behavioral Health Services.* 3. *Reducing preventable thirty (30) day hospital readmissions.* 4. *Social determinants of health and health equity.* Note: Refer to Plan Year 2022 PIP Memorandum for MCOs from DHCFP 5-19-2022. 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) Contract 7.9.5.4-7.9.5.6	• HPN_2022 Medicaid QI Workplan, pg 6	
MCO Description of Process: Performance Improvement Projects (PIPs) are included as part of the QI Program Description and the QI Workplan. While we did receive the 5/19/22 email from the DHCFP, training for the 2022 PIPs was offered by HSAG on June 9th, therefore there is no applicable SOP for this process in affect during this audit timeframe and no documentation of "active" PIPs.		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
21. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by DHCFP. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) Contract 7.9.5.2; 7.9.5.2.1-7.9.5.2.4	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 22 • HPN_2022 Medicaid QI Workplan, pg 6	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Performance Improvement Projects (PIPs) are included as part of the QI Program Description and the QI Workplan. While we did receive the 5/19/22 email from the DHCFP, training for the 2022 PIPs was offered by HSAG on June 9th, therefore there is no applicable SOP for this process in affect during this audit timeframe and no documentation of "active" PIPs.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the 2022 Medicaid Quality Program Description and workplan included the requirements for this element, DHCFP did not announce the required PIP topics to the MCOs until May 2022. Therefore, HSAG did not evaluate implementation of the requirements under this element. The MCO's compliance with all PIP-related requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
22. *The MCO's PIPs are described in the annual written QAPI program description and include:* a. *How the PIP relates to the MCO's other Population Health initiatives and DHCFP's Quality Strategy.*	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:**	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
b. *The theory of change for each PIP (e.g., cause and effect diagrams, key driver diagrams).* c. *Criteria considered when choosing and prioritizing the MCO's PIPs by population stream.* d. *The MCO's evaluation strategy addressing the process, outcome, and balancing measures for each initiative, including:* i. *Baseline, milestones, and target goals.* ii. *Timeframes for baseline, milestones, and target goals.* iii. *Data sources.* iv. *Numerator and denominators for each measure.* v. *Frequency of measurement (e.g., daily, weekly, monthly)* Contract 7.9.5.8;7.9.5.8.1-7.9.5.8.4; 7.9.5.8.4.1-7.9.5.8.4.4	• HPN_2022 Medicaid QIPD, pg 22 • HPN_2022 Medicaid QI Workplan, pg 6	
MCO Description of Process: Performance Improvement Projects (PIPs) are included as part of the QI Program Description and the QI Workplan. While we did receive the 5/19/22 email from the DHCFP, training for the 2022 PIPs was offered by HSAG on June 9th, therefore there is no applicable SOP for this process in affect during this audit timeframe and no documentation of "active" PIPs.		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
23. The MCO must report the status and results of each PIP to DHCFP as requested, but not less than once per year. a. *Each PIP is completed in a reasonable time period so as to generally allow information on the success of PIPs to be available to DHCFP for its annual review of the MCO's QAPI program.* 42 CFR §438.330(d)(3)	**HSAG Recommended Evidence:** • Evidence of annual submission, including the documentation that was submitted, of all PIPs to DHCFP **Evidence as Submitted by the MCO:** N/A	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.2.8; 7.9.5.3		
MCO Description of Process: There was no annual PIP submission between January and May of 2022. Training was delivered on June 9th and current PIPs are in process.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the QI Program Description and annual evaluation included the requirements for this element, DHCFP did not announce the required PIP topics to the MCOs until May 2022. Therefore, HSAG did not evaluate implementation of the requirements under this element. The MCO's compliance with all PIP-related requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
Critical Incident Management System		
24. The QAPI program must include participation in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). 42 CFR §438.330(b)(5)(ii) Contract 7.9.14	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_Critical Incident Reporting Job Aid • HPN_Medicaid Critical Incident Reporting Training Document • HPN_Critical Incident Initial Report_BLANK • HPN_Critical Incident Follow-Up Report_BLANK	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: HPN understands that the Critical Incident Reporting Policy was created outside the Scope of the audit period. The policy was in process as we performed training on the CI Reporting requirements to staff.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: Although the MCO implemented a process through a job aid and began training staff (e.g., community health workers, clinical operations, behavioral health) in January 2022 for submitting incident reports to DHCFP, the MCO's formal policy was not approved until July 2022. **Recommendations:** HSAG recommends that the MCO include detailed information within its QAPI-related documents (e.g., program description, workplan, annual evaluation) about the MCO's participation in DHCFP's efforts to prevent, detect, and remediate critical incidents. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The QAPI program must include participation in DHCFP's efforts to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare according to 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs in accordance with 42 CFR §441.302(h).		
25. *The MCO must designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of Section 7.9.14 of the Contract.* a. *This position may be assigned as a responsibility to a lead within the quality department and may or may not be a full time equivalent (FTE).* Contract 7.9.14.1	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job description **Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_Critical Incident Report Tracking 2022	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The CI form was created and is maintained within our Integrated Care Management (ICM) system by Karen Wright, Associate Director of Case Management. The trainings are managed by Devan Seawright, Program Manager. Seth Wray, Compliance Analyst, has been designated to administer the CI processes, including the submission and tracking of the CI reports.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
26. The MCO develops and implements policies and procedures, subject to DHCFP review and approval, to: a. Address and respond to incidents. b. Report incidents to the appropriate entities per required timeframes. c. Track and analyze incidents. 42 CFR §438.330(b)(5)(ii) Contract 7.9.14	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports • Committee meeting minutes with aggregated critical incident analysis • Provider remediation plan template(s) **Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_Critical Incident Reporting Training Document • HPN_Critical Incident Reporting Job Aid • HPN_Critical Incident Report Tracking 2022 • HPN_CIR Case 1_Initial • HPN_CIR Case 1_Resolution and Closure • HPN_CIR Case 2_Initial • HPN_CIR Case 2_Resolution and Closure • HPN_CIR Case 3_Initial • HPN_CIR Case 3_Resolution and Closure	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: The Critical Incident Reporting policy did not identify or include procedures for tracking and analyzing critical incidents. **Recommendations:** The MCO submitted a critical incident tracking log that contained several data fields (e.g., name of member, Medicaid ID, initial report date, date sent to state). HSAG recommends that the MCO add data fields to its critical incident tracking log for the type and location of the incident, as the data captured from these data fields could be used to trend incidents and identify opportunities for improvement. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: The MCO must ensure that it develops and implements policies and procedures, subject to DHCFP review and approval, to address and respond to incidents, report incidents to the appropriate entities according to required time frames, and track and analyze incidents.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
27. *The MCO submits an individual critical incident report for the following incidents:* a. *Homicide or attempted homicide by a member.* b. *A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility licensed by the State to provide publicly funded behavioral health services.* c. *An unexpected death of a member that occurs in a facility licensed by the State to provided publicly funded behavioral health services.* d. *Abuse, neglect, or exploitation of a member (not to include child abuse).* e. *Violent acts allegedly committed by a member, to include:* i. *Arson.* ii. *Assault resulting in serious bodily harm.* iii. *Homicide or attempted homicide by abuse.* iv. *Drive-by shooting.* v. *Extortion.* vi. *Kidnapping.* vii. *Rape, sexual assault, or indecent liberties.* viii. *Robbery.* ix. *Vehicular homicide.* f. *Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e., Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_CIR Case 1_Initial • HPN_CIR Case 1_Resolution and Closure • HPN_CIR Case 2_Initial • HPN_CIR Case 2_Resolution and Closure • HPN_CIR Case 3_Initial • HPN_CIR Case 3_Resolution and Closure	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
g. *Any even involving a member that has attracted or is likely to attract media attention.* Contract 7.9.14.2; 7.9.14.2.1-7.9.14.2.5; 7.9.14.2.5.1-7.9.14.2.5.9		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
28. *The MCO reports critical incidents within one (1) business day in which the MCO becomes aware of the event. The report must include:* a. *The date the MCO became aware of the incident.* b. *The date of the incident.* c. *A description of the incident.* d. *The name of the facility where the incident occurred, or a description of the incident location.* e. *The name(s) and age(s) of member(s) involved in the incident.* f. *The name(s) and title(s) of facility personnel or other staff involved.* g. *The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement.* h. *The member's whereabouts at the time of the report, if known (i.e., home, jail, hospital, unknown, etc.) or actions taken by the MCO to locate the member.* i. *Actions planned or taken by the MCO to minimize harm resulting from the incident.* j. *Any legally required notifications made by the MCO.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Critical incident timeliness reports • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_CIR Case 1_Initial • HPN_CIR Case 1_Resolution and Closure • HPN_CIR Case 2_Initial • HPN_CIR Case 2_Resolution and Closure • HPN_CIR Case 3_Initial • HPN_CIR Case 3_Resolution and Closure	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.14.3; 7.9.14.3.1-7.9.14.3.10		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
29. *The MCO submits follow-up reports using the Incident Reporting System and closes the case within forty-five (45) calendar days after the critical incident was initially reported. A case cannot be closed until the following information is provided:* a. *A summary of any debriefings.* b. *Whether the member is in custody (jail), in the hospital, or in the community.* c. *Whether the member is receiving services and include the types of services provided.* d. *If the member cannot be located, the steps the MCO has taken to locate the member using available, local resources.* e. *In the case of the death of a member, verification from official sources that includes the date, name, and title of the sources. When official verification cannot be made, the MCO must document all attempts to retrieve it.* Contract 7.9.14.4; 7.9.14.4.1-7.9.14.4.5	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports with resolutions • Committee meeting minutes • Critical incident timeliness reports • **Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_Critical Incident Report Tracking 2022 • HPN_CIR Case 1_Initial • HPN_CIR Case 1_Resolution and Closure • HPN_CIR Case 2_Initial • HPN_CIR Case 2_Resolution and Closure • HPN_CIR Case 3_Initial • HPN_CIR Case 3_Resolution and Closure	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Member Participation in the QAPI		
30. *Members are kept informed about the quality initiatives and results through member newsletters and website postings and through the Member Advisory Board.* Contract 7.9.4.15.1	**HSAG Recommended Evidence:** • Member newsletters and website screenshots demonstrating members are informed of quality initiatives **Evidence as Submitted by the MCO:** • HPN_Spring 2022 HealthTALK Magazine XIV, pg 10 • Quality – Member – HPN Medicaid	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Quality initiatives will be highlighted in the Fall 2022 Member Newsletter, publishing in October (outside the audit period).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO enhance information provided to members about quality initiatives and results to include additional detail and any actions taken based on the analyses of data. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
Provider Participation in the QAPI		
31. *Network providers and other providers must be kept informed about the written QAPI program through provider newsletters and updates to the provider manual.* Contract 7.9.4.14.1	**HSAG Recommended Evidence:** • Provider newsletters and website screenshots demonstrating providers are informed of quality initiatives • Provider manual **Evidence as Submitted by the MCO:** • HPN_Provider Summary Guide_Std XIV pg 24, sec 8.25 • HPN_Medicaid Webex ppt 2.9.22: pgs 26-34 • HPN_QI Website Screenshot • Quality Corner - Doctor / Provider - Health Plan of Nevada • HPN_2022 Summer ProviderTALK Magazine, pg 7	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The HPN_2022 Summer ProviderTALK Magazine was mailed and posted online on 6/23/22.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
Plan of Correction Procedure		
32. *The MCO implements a Plan of Correction (POC) to identify improvements and/or enhancements of existing outreach, education, and case management activities, which will assist the MCO to improve the quality rates/scores. A POC must include, but may not be limited to, the following:* a. *Specific problem(s) which require corrective action;* b. *The type(s) of corrective action to be taken for improvement;* c. *The goals of the corrective action;* d. *The timetable for action;* e. *The identified changes in process, structure, internal/external education;* f. *The MCO's staff person(s) responsible for implementing and monitoring the POC;* g. *The POC should also identify improvements and enhancements of existing outreach and case management activities, if applicable.* Contract 7.9.2.7.1-7.9.2.7.9	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active internal POCs during the time period under review **Evidence as Submitted by the MCO:** • HPN_WRHCO 359 Plan of Correction Policy	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Per Contract section 7.9.2.7.10. Unless otherwise specified by the State, the Contractor has thirty (30) Calendar Days from date of notification by the State to submit a POC, as specified. HPN did not receive notification of a required plan of correction during the audit period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's Plan of Correction Policy included the requirements for this element.		
Required Actions: None.		

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Requirement	**Supporting Documentation**	**Score**
33. *The QAPI includes written procedures for taking corrective action, also referred to as POC and as described in Section 7.9.2.7 of the Contract, whenever inappropriate or substandard services are furnished, or services that should have been furnished were not. These written corrective action procedures includes:* a. *Specification of the types of problems requiring corrective action;* b. *Specification of the person(s) or body responsible for making the final determinations regarding quality problems;* c. *Specific actions to be taken; provision of feedback to appropriate health professionals, providers and staff;* d. *The schedule and accountability for implementing corrective actions;* e. *The approach to modifying the corrective action if improvements do not occur; and* f. *Procedures for terminating the affiliation with the physician, or other health professional or provider.* Contract 7.9.4.8.1; 7.9.4.8.1.1-7.9.4.8.1.6	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • All active provider POCs during the time period under review **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pgs 23-26	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There were no active provider POCs during the audit period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
34. *As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made.* a. *In addition, changes in practice patterns must be monitored.* b. *The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.* Contract 7.9.4.8.2	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • Evidence of monitoring of all active provider POCs during the time period under review **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pgs 23-26	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There were no active provider POCs during the audit period.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO did not have any POCs implemented during the time period under review; however, the MCO's Plan of Correction Policy included the requirements for this element.		
Required Actions: None.		
Accountability to the Governing Body		
35. *The governing body has approved the overall QAPI and the annual QAPI.* Contract 7.9.4.10.1	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval **Evidence as Submitted by the MCO:** • HPN_Asst Secretary Cert_Medicaid QIPD Approval • HPN_Asst Secretary Cert_Medicaid QIPE Approval	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The HPN Board of Directors approves the QI Program Evaluation, the QI Program Description and the QI Workplan each year during their April meeting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
36. *The governing body has formally designated an entity or entities within the MCO to provide oversight of the QAPI program and is accountable to the governing body, or has formally decided to provide such oversight as a committee of the whole.* Contract 7.9.4.10.2	**HSAG Recommended Evidence:** • QAPI program description **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pgs 12-13	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
37. *The governing body routinely receives written reports from the QAPI program describing actions taken, progress in meeting quality assurance objectives, and improvements made.* Contract 7.9.4.10.3	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the MCO:** • HPN_Quality Improv_BOD Report March 2022, entire document • HPN_Agenda – Board Meeting, pg 2	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: There was only one Board of Directors meeting held during the audit timeframe and that QI report is submitted for review. The Quality Improvement department reports live every quarter to the HPN BOD. Minutes from the Board of Directors' meeting are not available, but we have submitted an agenda indicating that the QI department was presenting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
38. *The governing body formally reviews on a periodic basis, but no less frequently than annually, a written report on the QAPI program.* a. *This annual quality program evaluation report is submitted to DHCFP in the second calendar quarter and at minimum must include studies undertaken; results; subsequent actions and aggregate data on utilization and quality of services rendered; and an assessment of the QAPI's continuity, effectiveness, and current acceptability.* Contract 7.9.4.10.4	**HSAG Recommended Evidence:** • Governing body meeting minutes with annual QAPI program approval • Annual written report reviewed by the governing body • Evidence the annual QAPI program evaluation was submitted to DHCFP **Evidence as Submitted by the MCO:** • HPN_Asst Secretary Cert_Medicaid QIPE, entire document • HPN_2021 Medicaid QIPE, pg 1	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Quality Improvement Program Evaluation is submitted to the Board of Directors in the first quarter of each year, indicating the plan's progress made in the prior year.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
39. *Upon receipt of regular written reports delineating actions taken and improvements made, the governing body takes action when appropriate, and directs that the operational QAPI program be modified on an ongoing basis to accommodate review findings and issues of concern with the MCO.* a. *This activity is documented in the minutes of the meetings of the governing board in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to quality assurance.* Contract 7.9.4.10.5	**HSAG Recommended Evidence:** • Three consecutive written reports reviewed by the governing body • Three consecutive governing body meeting minutes **Evidence as Submitted by the MCO:** • HPN_Quality Improv_BOD Report March 2022, entire document • HPN_Agenda – Board Meeting, pg 2	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: There was only one Board of Directors meeting held during the audit timeframe and that QI report is submitted for review. The Quality Improvement department reports live every quarter to the HPN BOD. Minutes from the Board of Directors' meeting are not available, but we have submitted an agenda indicating that the QI department was presenting.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
QAPI Program Reviews, Analysis, and Evaluation		
40. The MCO must develop a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation must include: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. d. *Quality assurance studies and other activities completed.* e. *Trending of clinical and service indicators and other performance data.* f. *Demonstrated improvements in quality.* g. *Areas of deficiency and recommendations for corrective action.* h. *An evaluation of the overall effectiveness of the QAPI program.* 42 CFR §438.330(e) Contract 7.9.2.4; 7.9.4.9.2	**HSAG Recommended Evidence:** • QAPI program evaluation • Evidence of QAPI program evaluation annual submission to DHCFP **Evidence as Submitted by the MCO:** • HPN_2021 Medicaid QIPE Final, pgs 6, 7-28, 30 • HPN_Submission of QIPE	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The most recent QI Program Evaluation is for the year ending December 31, 2021, so it may not be fully compliant with the current Medicaid contract and the requirements indicated for this audit. The submitted Quality Improvement Program Evaluation (QIPE) includes multiple		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
examples of annual tracking and trending of clinical measures as well as barriers and interventions for each program designed to address those measures. Also included are indicators of service quality such as appeals and grievances, telephone statistics and survey results. Per Section 7.9.4.10.4 the QIPE must be submitted in the second quarter. The QIPE was submitted to the State on 6/8, outside the audit period. However, we have included evidence of submitted it on 6/8 to illustrate our compliance.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
41. *The QAPI program evaluation provides evidence that quality assurance activities have contributed to significant improvements in the care delivered to members and include:* a. *A description of DHCFP and MCO-initiated improvement projects, including the annual PIPs; and the outcomes and trended results for each improvement project, including documentation of successful and unsuccessful interventions.* b. *A summary of the MCO's assessment of the effectiveness of improvement projects based on performance measurement data.* c. *A description of how the MCO meets the requirements for the development and dissemination of clinical practice guidelines.* d. *A description of mechanisms the MCO uses to detect both underutilization and overutilization.* e. *A description of mechanisms the MCO uses to assess the quality and appropriateness of care furnished to members with special health care needs and members receiving long-term services and supports.* f. *A description of the MCO's efforts to prevent, detect, and remediate critical incidents.* g. *Summary of quality committee structure and activity providing structure, at a minimum for the internal quality improvement*	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** • HPN_2021 Medicaid QIPE, pgs 6, 7-28, 30, 67 • HPN_2021 UM Program Eval, pg 27 • HPN_2022 Medicaid QIPD, pg 15 • HPN_2022 UMPD NV Addendum, pg 14	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
committee that monitors the annual quality strategy and work plan; and internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols and policies. h. *An assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations, with a report of aggregate data indicating methods used to monitor compliance.* i. *An assessment of the quality and appropriateness of care furnished to members with special health care needs, with a report of aggregate data indicating the number of members identified and methods used to evaluate the need for direct access to specialists.* j. *A demonstration of improvement in an area of poor performance in care coordination for members with special health care needs and behavioral conditions.* k. *A report on the member grievance and appeal system.* l. *Monitoring and enforcement of consumer rights and protections that ensures consistent response to complaints of violations of consumer rights and protections.* Contract 7.9.4.9.3; 7.9.4.9.3.1-7.9.4.9.3.11		
MCO Description of Process: The most recent QI Program Evaluation is for the year ending December 31, 2021, so it may not be fully compliant with the current Medicaid contract and the requirements indicated for this audit.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the contract effective January 2022 included additional QAPI evaluation requirements which will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
42. *The MCO's evaluation also includes:* a. *How the MCO will incorporate the results in its quality improvement strategy.* b. *How the MCO plans to update its quality improvement strategy based on the findings of the self-evaluation.* Contract 7.9.4.9.5.1-7.9.4.9.5.2	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** • HPN_2022 Medicaid QIPD, pg 28	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the requirements for this element were not applicable for the time period under review. Of note, the contract effective January 2022 included these additional QAPI evaluation requirements, which will be assessed during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program						
Met	=	37	X	1	=	37
Not Met	=	2	X	0	=	0
Not Applicable	=	3				
Total Applicable	=	39	**Total Score**		=	37
Total Score ÷ Total Applicable					=	95%

Appendix B. Compliance Review Corrective Action Plan

SFY 2021–22 Compliance With Standards Review Tool CAP Template

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
General Rules			
42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.*	**Evidence as Submitted by the MCO:** • HPN_Cred-Recred Policy whole document • HPN_Network Participation Standards whole document • HPN_NV Initial Cred Application (NDOI-901) • Join Our Network - Doctor / Provider - Health Plan of Nevada	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		

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

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	HSAG Findings: The MCO's policy listed the following practitioners who are not to be credentialed: • Certified Massage Practitioner • Certified Registered Nurse Anesthetist • Clinical Nurse Specialist • Dentists who are not oral surgeons • Licensed Practical Nurse • Registered Behavioral Therapist • Pathologist • Radiologist • Anesthesiologist • Emergency Room/Urgent Care Practitioner • Neonatologist • Respiratory Therapist • Body Imagery The MCO's policy also listed the following organizational provider types that are not to be credentialed: • Laboratories • Outpatient Physical Therapy • Speech Pathology Providers • Portable X-Ray Supplies • Durable Medical Equipment Providers • Hearing Aid Centers • Rural Health Clinics (RHCs) • Federally Qualified Health Centers (FQHCs) • Group Homes • Adult Day Care Centers Additionally, the MCO's universe file for the review period included only three organizational providers, all of which were Ambulatory Surgery Centers (ASCs). During the site review, HSAG reviewers expressed their concern regarding the low		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	volume of organizational providers being credentialed and recredentialed. Additionally, while some of the practitioners who were not being credentialed may be appropriate (e.g., practitioners who practice exclusively in an inpatient setting or free-standing facility and provide care to members only because the members are directed to the facility), HSAG also expressed concern with several provider types, including organizations, that were not being credentialed by the MCO. After the site review, the MCO explained that it verified that its provider types which require credentialing align with NCQA and the MCO's parent company, excluding clinical laboratories. The MCO indicated that it will update its credentialing policy to include clinical laboratories moving forward and will work to credential all existing contracted laboratories in the next six months. The MCO further explained that it will discuss updating the list of provider types that require credentialing beyond NCQA and the MCO's parent company's requirements with the credentialing committee. While the MCO is taking proactive steps to address this finding, in review of the MCO's contract with DHCFP, Section 7.6.2.3 requires the MCO to credential and recredential providers seeking network provider status with the MCO. Therefore, all providers who have network status with the MCO, and who would be displayed as a network provider in the provider directory, must complete the MCO's formal credentialing process. Additionally, a laboratory is a provider type licensed by the Nevada Division of Public and Behavioral Health (DPBH); therefore, it is unclear why clinical laboratories would not have been part of the MCO's credentialing process in the State of Nevada and for Nevada Medicaid. In response to the MCO's low volume of organizational providers being credentialed, the MCO explained that in late 2021 there was a significant turnover in credentialing staff that affected completion rates, and the MCO provided a chart that demonstrated the historical volumes of organizational providers being credentialed and recredentialed during each quarter of 2020 and 2021. While these volumes were higher, they were still relatively low (minimum of three providers and maximum of 18 providers for initial credentialing per quarter; minimum of one provider and maximum of 18 providers for recredentialing per quarter). The provider types not historically credentialed by the MCO may explain this lower volume. Also, generally speaking, the number of providers being recredentialed was less than the providers being initially credentialed. In HSAG's experience, the volume of providers being recredentialed far exceeds the number of providers being initially credentialed for existing MCOs. The MCO should conduct an analysis of this general observation. **Recommendations:** The practitioner credentialing case file sample selections did not include a child/adolescent psychiatrist or psychologist provider type. As such, HSAG requested evidence of credentialing files for these provider types and corresponding screen shots of the provider directory to demonstrate that the MCO was collecting the age bands (0–6, 7–12, 13–17, and 18–21) served by these providers. After the site review, the MCO submitted a screen shot of a provider profile in the provider directory that included the following: "…Members 18 years of age or younger," but the directory did not break down		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	the specific age bands. However, in the MCO's database, the profile for this provider included the breakdown of the age bands. As the MCO demonstrated the ability to document the age bands (and the provider directory was not in the scope of this year's compliance review), this finding was not considered a deficiency. However, HSAG strongly recommends that the MCO ensure that the specific age bands for all child/adolescent psychiatrist or psychologist provider types are being collected at the time of credentialing and included in the provider directory. The MCO further explained that with the implementation of the new contract, the MCO contacted all in-network psychiatrists and psychologists regarding the age bands, and very few of the providers responded; and if they did, it was to report that they accepted all ages. However, the MCO must require its providers to report the specific age bands for child/adolescent psychiatrists and psychologists at the time of credentialing as required by its contract with DHCFP. HSAG strongly recommends that the MCO make this a mandatory element in order for these provider types to be initially credentialed or recredentialed. Also, the age bands in the MCO's standard operating procedure (SOP) were outdated and must be updated accordingly. Lastly, HSAG was unable to locate the age limitations on the provider's profile when reviewing the online provider directory. In follow-up to this observation, the MCO explained that the age limitations were viewable on the "Group Affiliations" link. The MCO further explained that this information is supposed to pull for both the group and individual profiles and that staff are working to correct this issue. HSAG strongly recommends that the MCO proceed with its plan to correct the provider directory as this information is required to be made available to members. As HSAG reviewers were challenged to locate this information without direction from the MCO, members may also be challenged to locate this information. Implementation of HSAG's recommendations will be evaluated during future compliance reviews. The MCO may receive a score of *Not Met* if these recommendations are not implemented.		
	Required Actions: The MCO must follow a documented process for credentialing and recredentialing network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorder (SUD), and LTSS providers. If State regulations or provider licensure laws conflict with NCQA standards, State regulations and provider licensure laws control the credentialing process. In accordance with the MCO's contract with DHCFP (Section 7.6.2.3), the MCO must credential and recredential providers seeking network provider status with the MCO.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
File Reviews			
42 CFR §438.214 Contract 7.6.2.3.4	10. The MCO complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool.	**Evidence as Submitted by the MCO:** • HPN_Credentialing SOP_Verification Sources • HPN_Cred-Recred Policy pg 32 - 33 • HPN_NV ReCred Application (NDOI-901) • HPN_ReCred_Nevada Network Denial Letter Template	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: No adverse recredentialing decisions were made during the lookback period.		
	HSAG Findings: The case file review indicated that a provider performance review occurred at the time of recredentialing and included a review of the following categories: "QM/RM/CRR," "Utilization Management," and "Satisfaction Survey." However, in further discussion with MCO staff members, utilization management data were not proactively being assessed for provider-specific performance (e.g., over- and underutilization of services). MCO staff members reported that they are not specifically looking at utilization management and that this line item is part of the MCO's checklist template. The MCO must define the utilization management data and thresholds being considered. Additionally, one case file did not include "Satisfaction Survey" on the checklist. MCO staff members explained that if an item was not on the list, there were no data available for that provider. However, the MCO should be documenting in the recredentialing file that this activity was considered but that no data were available to demonstrate compliance with this requirement.		
	Required Actions: The MCO must comply with all recredentialing requirements in accordance with its contract with DHCFP.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

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

Standard IX—Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Notice of Privacy Practices			
45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1)(i-viii) 45 CFR §164.520(c)(1-3)	11. The MCO's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCO, and of the member's rights and the MCO's legal duties with respect to PHI. a. The MCO must provide a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1)(i-viii). b. The MCO must make the notice available to its members on request as required by 45 CFR §164.520(c)(1-3).	**Evidence as Submitted by the MCO:** • HPN_UHG Privacy Policy Manual, Section 3.100 – 3.140, pages 46 – 49. • HPN_UHC Privacy Notice Policy pgs 2-3, 6 • HPN_Member Handbook_Confidentiality pg 85	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: Although the Privacy Policy Manual stipulated all Notice of Privacy Practices components under federal rule, the Health Plan Notices of Privacy Practices included as part of the January 2022 member handbook reflected the following gap: • In accordance with 45 CFR §164.520(b)(1), the header in the Notice of Privacy Practices (NPP) must include the following statement, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY." The MCO's header indicated, "THIS NOTICE SAYS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT SAYS HOW YOU CAN ACCESS THIS INFORMATION. READ IT CAREFULLY." Although this statement is similar, it does not indicate within the header statement that the notice also describes how medical information will be disclosed. After the site review, the MCO stated, "we are of the opinion that our NPPs meet the requirements of CFR Sec. 164.520(b) and our obligations to comply with a fifth (5th) grade reading requirements in accordance with the Flesh Kincaid Grade Level pursuant to regulatory and contractual requirements we have with the various state Medicaid agency's we service." Additionally, the MCO provided comments from the Department of Health and Human Services (HHS), including:		

Standard IX—Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Additionally, the Privacy Rule requires that the NPP be written in plain language, and we note that some covered entities may have obligations under other laws with respect to their communication with affected individuals. For example, to the extent a covered entity is obligated to comply with Title VI of the Civil Rights Act of 1964, the covered entity must take reasonable steps to ensure meaningful access for Limited English Proficient persons to the services of the covered entity, which could include translating the NPP into frequently encountered languages. In addition, we agree with the commenters who suggested that covered entities have flexibility and discretion to determine how to draft and prepare their NPPs. Because each NPP will vary based on the functions of the individual covered entity, there is no 'one size fits all' approach. However, we continue to explore options for making model or best practice language available. While HSAG agrees that MCOs have the flexibility to update their notices to comply and align with State requirements, HHS is very clear within the Federal Register that "…covered entities must include prominent and specific language in the notice that indicates the importance of the notice. This is the only specific language we require covered entities to include in the notice. The header must read, "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY." Please refer to the Federal Register at https://www.federalregister.gov/documents/2000/12/28/00-32678/standards-for-privacy-of-individually-identifiable-health-information. **Recommendations:** Although the Notice of Privacy Practices published on the MCO's website included the appropriate header statement, this version of the notice was not provided as evidence for this compliance review and is not the same version of the Notice of Privacy Practices provided to members on enrollment. As such, the MCO should consider updating the Notice of Privacy Practices in the member handbook to align with the Notice of Privacy Practices published to the MCO's website. This version of the notice was also more comprehensive and was in a more user-friendly format. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: The MCO must provide members with a notice that contains the elements required by 45 CFR §164.520(b)(1)(i–viii).		

Standard IX—Confidentiality			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Grievance System General Requirements			
42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §438.228 Contract 7.8.10.6.1; 7.8.10.6.	3. A member may file a grievance with the MCO at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.	**Evidence as Submitted by the MCO:** • HPN_Grievance Policy pg 3 • HPN_Member Handbook_G & A pg 69, 75	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: HPN did not have any Providers filing a grievance on behalf of the member during the audit period.		
	HSAG Findings: For most grievances reviewed as part of the case file review, the member filed the grievance. However, one grievance was filed by the mother of an adult member, and there was no evidence to support that the MCO attempted to obtain consent or that the mother was the legally authorized representative. Additionally, during the site review, MCO staff members confirmed they do not obtain consent when a grievance is filed by a provider or authorized representative on behalf of a member; instead, they would work the grievance and then would send the acknowledgment and resolution letters to the member. However, federal rule requires that written consent be obtained from a provider or an authorized representative when a grievance is being filed on a member's behalf. **Recommendations:** The member handbook supported that the member could file a grievance at any time but did not include that providers and authorized representatives may also file a grievance with the member's written consent. HSAG recommends that the MCO update the member handbook to explain that providers or authorized representatives may file a grievance on the member's behalf with the member's written consent. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: When a grievance is filed by a provider or an authorized representative on behalf of the member, the MCO must obtain the member's written consent.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

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

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Timely Resolution and Notification of Grievances			
42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §438.228 Contract 7.8.10.9.1.1; 7.8.10.11.1	7. The MCO must resolve each grievance and provide notice as expeditiously as the member's health condition requires. a. The MCO must resolve the grievance and send *written* notice to the affected parties *no later than ninety (90) calendar days* from the day the MCO receives the grievance. b. *The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.* c. The notice must meet the standards described at 42 CFR §438.10 *and include the results of the resolution process and the date it was completed*	**Evidence as Submitted by the MCO:** • HPN_Grievance Policy pg 2-3 • HPN_Grievance Outcome Letter Template	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: Through the case file review, MCO staff members demonstrated that they were contacting members in most instances to inform them that the grievance had been resolved and that they would receive a written notification. However, the MCO staff members were not providing details of the resolution unless requested by the member during the call. The intent of the requirement is that members are being provided with detailed information about the actual resolution of the grievance, and not that the grievance was concluded. **Recommendations:** The member handbook stated that grievances will be resolved within 90 days; however, the acknowledgement letters to members indicated the grievance would be resolved within 30 days. HSAG recommends that the MCO update its member-facing materials to consistently provide the time frame in which grievances will be resolved. Implementation of this recommendation will be evaluated during future compliance reviews. Additionally, HSAG is also making a recommendation to DHCFP to reduce the current 90-day time frame allowance.		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must also make reasonable efforts to provide oral notice of the resolution of the grievance.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Timely Resolution and Notification of Grievances			
42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 7.8.10.9.3	9. If the MCO extends the grievance resolution time frame not at the request of the member *(after DHCFP approval for the extension)*, it must complete all of the following: a. Make reasonable efforts to give the member prompt oral notice of the delay. b. Within two (2) calendar days give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.	**Evidence as Submitted by the MCO:** • HPN_Provider Summary Guide Section 8.8 pg 6 • HPN_Member Handbook_G & A pg 75 • HPN_Complaints_Closed_010122-053122	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: HPN does not have any examples of extensions because we have an internal standard of resolving grievances within 30 days and have provided a log showing that we meet that timeframe. An extension would only apply beyond the 90 day requirement. HPN has never had a member request an extension for resolution of a Grievance.		
	HSAG Findings: Although the Provider Summary Guide and member handbook indicated that the time frame for resolving grievances may be extended by 14 days if the extension will benefit the member, there was no evidence provided to support the process that must occur if an extension is taken, including that the MCO has a process in place to contact the member to explain the delay, and within two days give the member written notice of the reason why the time frame is being extended and that they can file a grievance if they disagree with the decision. Although the MCO staff indicated that they have not had a grievance extension, the MCO must have a process in place to ensure that, should an extension be necessary in the future, MCO staff members are aware of the process that must be followed. Additionally, if the acknowledgement letters indicate that the grievance will be resolved in 30 days, which is internal policy, the member should be notified of an extension if the grievance will not be resolved within 30 days.		
	Required Actions: If the MCO extends the grievance resolution time frame not at the request of the member (after DHCFP's approval for the extension), it must make reasonable efforts to give the member prompt oral notice of the delay; and within two		

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

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(d)(2)(ii) 42 CFR §438.228 Contract 7.8.10.11.1	27. For notice of a *standard* and expedited appeal resolution, the MCO is *required to make a good faith effort* to provide oral notice *of the disposition in addition to the required written notice*.	**Evidence as Submitted by the MCO:** • HPN_Appeals Policy pg 7 • HPN_Rpt_Member Exp Appeals_Closed	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: According to the case file review, the MCO was not consistently notifying the member orally of the appeal resolution. For four cases, the member was only informed that a letter was being mailed, but the details of the resolution were not provided; for one case, the provider was notified of the resolution, but the member was not contacted; and for another case, no call attempts were made to notify the member orally of the resolution.		
	Required Actions: For notice of a standard and expedited appeal resolution, the MCO must make a good faith effort to provide oral notice of the disposition of the appeal in addition to the required written notice.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Continuation of Benefits			
42 CFR §438.424(a) 42 CFR §438.228 Contract 7.8.10.8.4	33. If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	**Evidence as Submitted by the MCO:** • HPN_Appeals Policy pg 9	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: HPN does not have any examples during the audit period of 1/1/22-5/31/22.		
	HSAG Findings: Three cases reviewed as part of the case file review indicated that three appeals were overturned by the MCO. After the site review, the MCO provided documentation requested by HSAG to demonstrate that services were authorized or provided within 72 hours from the date the MCO determined that the denial of services were reversed. For one case, although the appeal decision was made on March 9, 2022, the authorization was not updated in the system until March 15, 2022, which was outside of the required 72 hours.		
	Required Actions: If the MCO or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Contract or Written Arrangement			
42 CFR §438.230(c)(2) Contract 7.2.2.7	3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, *including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention*.	**Evidence as Submitted by the MCO:** • HPN_EyeMed Contract Exhibit C (Bookmarks) • HPN_WRHCO 352 Subcontract Requirements • HPN_OptumRx_Agreement_Original pgs 1, 4, 13, 16	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: While a Memorandum of Understanding (MOU) between the MCO and one of its delegates, responsible for performance credentialing functions on behalf of the MCO, included a provision requiring the delegate to comply with all State and federal credentialing requirements, the MOU did not specially require the delegate to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention as required by the MCO's contract with DHCFP. MCO staff members explained that there is a base agreement to the MOU. However, after the site review, the MCO indicated that the MOU is the MCO's standard procedure between internal business segments and confirmed there was no base agreement or additional documentation to submit. However, as the entity is performing delegated credentialing functions on behalf of the MCO, the MCO's written arrangements must comply with 42 CFR §438.230 and the MCO's contract with DHCFP.		
	Required Actions: The MCO must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

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

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Contract or Written Arrangement			
42 CFR §438.230(c)(3)(i-iv)	4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State,	**Evidence as Submitted by the MCO:** • HPN_EyeMed Contract Exhibit C (Bookmarks) • HPN_WRHCO 345 Delegation of Responsibilities to Subcontrators • HPN_OptumRx_Agreement_Original (page 9)	☐ Met ☒ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time		
	MCO Description of Process:		
	HSAG Findings: The MOU between the MCO and one of its delegates did not include the requirements of this element. MCO staff members explained that there is a base agreement to the MOU. However, after the site review, the MCO indicated that the MOU is the MCO's standard procedure between internal business segments and confirmed there was no base agreement or additional documentation to submit. However, as the entity is performing delegated credentialing functions on behalf of the MCO, the MCO's written arrangements must comply with 42 CFR §438.230 and the MCO's contract with DHCFP. Additionally, while the Statement of Work (SOW) for one of the MCO's delegates included the requirements of sub-elements (a) and (b), the requirements of sub-elements (c) and (d) were not located. The SOW did identify suspected Medicaid fraud as a means that would warrant an audit but stipulated that the delegate is subject to an audit during regular business hours, at various but necessary times by DHCFP, the examiner, or designee. However, the MCO must clarify that an audit may occur due to suspected fraud at any time. The time period for the right to audit (i.e., sub-element [c]) was not located in the SOW. After the site review, the MCO submitted the original Master Services Agreement (MSA) and explained that SOW No. 6, when Medicaid was included in the contract, states that all requirements in the MSA pertain to the SOW; and while the original SOW does not mention Medicaid, the SOW No. 6 incorporating Medicaid states that the MSA applies. However, while the MSA may apply, the language that meets the requirements of sub-element (c) and (d) is located under a Medicare addendum to the MSA. The MCO should have updated its MSA and/or SOW, and/or a Medicaid addendum when the Medicaid managed care regulations were updated in 2016 and required this specific language to be included in all Medicaid delegated written arrangements or contracts.		
	Required Actions: The MCO must ensure that all contracts or written arrangements indicate, and the delegate agrees that: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. • The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.		

Standard XI—Subcontractual Relationships and Delegation			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	• The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. • If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XII—Practice Guidelines			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Adoption of Practice Guidelines			
Contract 7.2.1.6.2.3	1. The MCO's Chief Medical Director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.	**Evidence as Submitted by the MCO:** • HPN_NMCMC Minutes 2-14-22, pg 5 • HPN_NMCMC Charter 2022, entire document	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review and include attendance by HPN's CMO.		
	HSAG Findings: The National Medical Care Management Committee (NMCMC) is responsible for the review of clinical policies, criteria, and guidelines recommended by the Medical Technology Assessment Committee (MTAC) and/or other appropriate committee, for all UnitedHealthcare plans. The MCO's chief medical officer (CMO) attends NMCMC meetings but is not a voting member. MCO staff members explained during the site review that although the MCO's CMO is not a voting member of the NMCMC, a NMCMC committee member is not prohibited from bringing items to the committee for discussion. While the MCO appears to be adopting all clinical care standards, practice guidelines, and protocols approved by the NMCMC, there was no local health plan-level process led by the MCO's CMO to adopt clinical care standards, practice guidelines, and protocols that specifically relate to the Nevada Medicaid program and the members served.		
	Required Actions: The MCO must ensure that the MCO's chief medical director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

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

Standard XII—Practice Guidelines			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Adoption of Practice Guidelines			
42 CFR §438.236 (b)(2) Contract 7.6.12.1.2	3. The MCO must adopt practice guidelines that consider the needs of the MCO's members.	**Evidence as Submitted by the MCO:** • HPN_NMCMC Minutes 2-14-22, pg 5 • Medical & Drug Policies and Coverage Determination Guidelines for Community Plan | UHCprovider.com	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review. The web link above allows providers to access and search for clinical guidelines.		
	HSAG Findings: While the MCO appears to be adopting all clinical care standards, practice guidelines, and protocols approved by the NMCMC, there was no local health plan-level process led by the MCO's CMO to adopt clinical care standards, practice guidelines, and protocols that specifically relate to the Nevada Medicaid program and the members served. Although the UnitedHealthcare *Community Plan Medical & Drug Policies and Coverage Determination Guidelines* indicated specific states in which the overarching medical policy library did not apply, Nevada was not included as one of these states.		
	Required Actions: The MCO must adopt practice guidelines that consider the needs of the MCO's members.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XII—Practice Guidelines			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Adoption of Practice Guidelines			
42 CFR §438.236 (b)(3) Contract 7.6.12.1.3	4. The MCO must adopt practice guidelines that are adopted in consultation with network providers.	**Evidence as Submitted by the MCO:** • HPN_NMCMC Minutes 2-14-22, pg 5 • HPN_Clinical Guideline Example, entire document • Medical & Drug Policies and Coverage Determination Guidelines for Community Plan | UHCprovider.com • HPN_BH UM Program Description pg 17-18	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The development and revision of clinical practice guidelines and clinical criteria is performed at the national UnitedHealthcare level by the National Medical Care Management Committee (NMCMC). Minutes from a meeting within the audit period are submitted for your review. A sample practice guideline is submitted as well.		
	HSAG Findings: Although the Behavioral Health Utilization Management Program Description indicated that clinical criteria were being reviewed by the Behavioral Health Utilization Management Subcommittee, the charter included as part of the program description did not support that Nevada Medicaid contracted providers were committee members. Additionally, no additional evidence was provided to support that Nevada Medicaid contracted providers were consulted by the NMCMC when adopting practice guidelines.		
	Required Actions: The MCO must adopt practice guidelines that are adopted in consultation with network providers.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			

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

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
General Rule			
42 CFR §438.242(a) Contract 7.12.2.1; 7.12.2.2; 7.12.4.1	1. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems must provide information on areas including, but not limited to: a. Utilization b. Claims payment c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility e. *Enrollment* f. *Eligibility* g. *Provider network data* h. *Encounter data* i. *Electronic Visit Verification (EVV)*	**Evidence as Submitted by the MCO:** • All documents below provide evidence on our Health Information System and should be used, along with the demonstration of our systems, as evidence for this Requirement.	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: HSAG requested screen shots of the MCO's system to confirm it had the capability to document the reason for disenrollment as provided by DHCFP on the enrollment and eligibility file. After the site review, a screen shot of a "Reason" displayed as "T090 Per tape/file transmit/dwnload" was provided. As this did not appear to be an actual reason for a disenrollment (e.g., 03 Death, 07 Termination of Benefits), HSAG requested further clarification; however, the MCO confirmed it had no additional documentation to submit.		
	Required Actions: The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements, including the reason for member disenrollment as provided by DHCFP.		

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Information Technology System for Care Management Programs			
Contract 7.5.6.8.2; 7.5.6.8.4	13. *The MCO has an integrated database that allows MCO staff that may be contacted by a member in Case Management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case, including the MCO's 24-hour Nurse Line. The integrated database must include all of the following:* a. *Administrative data* b. *Call center communications (contact tracking)* c. *Service authorizations* d. *HL7 inpatient and ER notifications* e. *Person centered care treatment plans* f. *Patient assessments* g. *Case management notes*	**Evidence as Submitted by the MCO:** • HPN_ICM User Guide: pages 47 Figure 3-9, pg 56 Section 4.1, pg 103 Section 5.5, and pg 133 Section 7.1 • HPN_Claims Transition Report Example	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: While the care managers could review member calls via a dashboard, only the "Reason" (e.g., "13/Dentist," "13/Prov Info") for the call was viewable, and the call notes were not pulled into the dashboard. After the site review, the MCO explained that the topic of the calls is generally enough to understand that the member has called the health plan and the care manager can discuss outstanding issues with the member; however, the call communications were not available to care management staff. MCO staff also explained they are working to ensure that care management staff members' permissions are current (e.g., access to the call center system).		

Standard XIII—Health Information Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must have an integrated database that allows MCO staff who may be contacted by a member in care management to have immediate access to and review of the most recent information within the MCO's information systems relevant to the case, including call center communications.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Critical Incident Management System			
42 CFR §438.330(b)(5)(ii) Contract 7.9.14	24. The QAPI program must include participation in efforts by DHCFP to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h).	**Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_Critical Incident Reporting Job Aid • HPN_Medicaid Critical Incident Reporting Training Document • HPN_Critical Incident Initial Report_BLANK • HPN_Critical Incident Follow-Up Report_BLANK	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: HPN understands that the Critical Incident Reporting Policy was created outside the Scope of the audit period. The policy was in process as we performed training on the CI Reporting requirements to staff.		
	HSAG Findings: Although the MCO implemented a process through a job aid and began training staff (e.g., community health workers, clinical operations, behavioral health) in January 2022 for submitting incident reports to DHCFP, the MCO's formal policy was not approved until July 2022. **Recommendations:** HSAG recommends that the MCO include detailed information within its QAPI-related documents (e.g., program description, workplan, annual evaluation) about the MCO's participation in DHCFP's efforts to prevent, detect, and remediate critical incidents. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: The QAPI program must include participation in DHCFP's efforts to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare according to 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs in accordance with 42 CFR §441.302(h).		

Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Critical Incident Management System			
42 CFR §438.330(b)(5)(ii) Contract 7.9.14	26. The MCO develops and implements policies and procedures, subject to DHCFP review and approval, to: a. Address and respond to incidents. b. Report incidents to the appropriate entities per required timeframes. c. Track and analyze incidents	**Evidence as Submitted by the MCO:** • HPN_WRHCO 364 Critical Incident Reporting • HPN_Critical Incident Reporting Job Aid • HPN_Medicaid Critical Incident Reporting Training Document • HPN_Critical Incident Initial Report_BLANK • HPN_Critical Incident Follow-Up Report_BLANK	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: The Critical Incident Reporting policy did not identify or include procedures for tracking and analyzing critical incidents. **Recommendations:** The MCO submitted a critical incident tracking log that contained several data fields (e.g., name of member, Medicaid ID, initial report date, date sent to state). HSAG recommends that the MCO add data fields to its critical incident tracking log for the type and location of the incident, as the data captured from these data fields could be used to trend incidents and identify opportunities for improvement. Implementation of this recommendation will be evaluated during future compliance reviews.		
	Required Actions: The MCO must ensure that it develops and implements policies and procedures, subject to DHCFP review and approval, to address and respond to incidents, report incidents to the appropriate entities according to required time frames, and track and analyze incidents.		

Standard XIV—Quality Assessment and Performance Improvement Program			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted