Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

Calendar Year 2022 External Quality Review Compliance Review Report

for

Molina Healthcare of Nevada, Inc.

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 **Molina Healthcare of Nevada, Inc.** (**Molina of Nevada**). 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 **Molina of Nevada** 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	11	9	2	1	**82%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**134**	**130**	**122**	**8**	**4**	**94%**

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.

Molina of Nevada achieved an overall compliance score of 94 percent, indicating adherence to most of the reviewed federal and State requirements. However, opportunities for improvement were identified in the areas of Provider Selection and Grievance and Appeal Systems as these program areas received performance scores below 90 percent. Detailed findings, including recommendations for program enhancements, are documented in Appendix A.

Corrective Action Process

For any elements scored *Not Met*, **Molina of Nevada** 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 12, 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, **Molina of Nevada** 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, **Molina of Nevada** 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 **Molina of Nevada**'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 **Molina of Nevada**'s corrective actions to determine the sufficiency of the CAP. If an action plan is determined to be insufficient, **Molina of Nevada** will be required to revise its CAP until deemed acceptable by HSAG and DHCFP.

To ensure the CAP is fully implemented, **Molina of Nevada** 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 **Molina of Nevada**'s CAP.

Appendix A. Review of the Standards

Following this page is the completed compliance review tool that HSAG used to evaluate **Molina of Nevada**'s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring **Molina of Nevada**'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:** • 4.8a Provider Compliance_Network Maintenance and Availability of Services 7.6.2.5 • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • CR02 Assessment and Reassessment of Organizational Providers Policy • CR02 Assessment and Reassessment of Organizational Providers Procedure • CR05 System Controls Policy	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: CR01 & CR02 are applicable to any provider applying to be contracted and those who are already contracted in the Molina network. The Molina credentialing program assures the network consists of quality providers who meet defined criteria and standards. Decisions to accept or deny a provider are outlined in the procedure. CR05 describes how credentialing information is stored, modified, and secured. The policy is in place to		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
assure Molina Healthcare Inc. (MHI) Credentialing Department has processes in place to protect the data and documentation obtained through the credentialing process. This includes collection, maintenance, securing, and audits of credentialing data and documents.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO update its policies, procedures, and/or workflows to clearly outline the MCO's process for implementing the requirements of sub-element (b). Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.* 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing form template (link to form is acceptable) • HSAG will also use the results of the File Reviews for Form NDOI-901 use **Evidence as Submitted by the MCO:** • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • CR02 Assessment and Reassessment of Organizational Providers Policy • CR02 Assessment and Reassessment of Organizational Providers Procedure • NV 2021 CR01 Nevada State Addendum • NV Credentialing Application	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: Molina has a uniform credentialing and recredentialing procedure for the selection and retention of all providers to include acute, primary, behavioral, substance use disorders and LTSS practitioners. Molina follows this documented procedure for credentialing and recredentialing network practitioners. The NV 2021 CR01 Addendum details the requirement to use ND01-901 for applicable provider types and state regulations/licensure laws.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: The case file review confirmed that the state-required Form NDOI [Nevada Division of Insurance]-901 was not consistently being used. These findings primarily related to providers being credentialed by one of the MCO's delegates, and MCO staff members confirmed that the delegate was using its own form. For one of the files pertaining to the MCO's cases, the provider was located in Arizona; therefore, Form NDOI-901 was inadvertently not pulled for this provider.		
Required Actions: The MCO and its delegates must use Form NDOI-901 when credentialing providers in accordance with the MCO's contract with DHCFP and the NAC.		
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:** • 4.8a Provider Compliance_Network Maintenance and Availability of Services 7.6.2.5 • CR01 Credentialing and recredentialing Practitioners Procedure • NV – Non-Discrimination Report Q1 & Q2 • Confidentiality Agreements • National PRC Charter	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: CR01 documents Molina does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable State law, solely based on that license or certification. Molina does not collect the data or make network participation decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the provider specializes. Molina does not discriminate against providers that serve high-risk populations or those who specialize in conditions that require costly treatment. This does not preclude Molina from		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
including in its network providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members. Confidentiality agreements are signed annually by our external PRC members. Our National PRC Charter is reviewed and approved annually. Monitoring for discrimination is completed biannually. An example of this report is included showing adverse decisions made by the PRC (Jan-June 2022).		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
4. The MCO may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCO declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision. b. In all contracts with network providers, the MCO must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) Contract 7.6.2.2.5	**HSAG Recommended Evidence:** • Policies and procedures • Documentation to support the prevention of and monitoring for discriminatory practices • Provider notice template • Example of one individual and one organizational executed provider contracts **Evidence as Submitted by the MCO:** • 8.3 Provider Status 7.6.2 • CR01 Credentialing and recredentialing Practitioners Procedure • NV – Non-Discrimination Report Q1 & Q2 • Confidentiality Agreements • National PRC Charter • Provider Notice Templates	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: CR01 documents Molina does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable State law, solely based on that license or certification. Molina does not collect the data or make network participation decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the provider specializes. Molina does not discriminate against providers that serve high-risk populations or those who specialize in conditions that require costly treatment. This does not preclude Molina from		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
including in its network providers who meet certain demographic or specialty needs; for example, to meet cultural needs of Members. Confidentiality agreements are signed annually by our external PRC members. Our National PRC Charter is reviewed and approved annually. Monitoring for discrimination is completed biannually. An example of this report is included showing adverse decisions made by the PRC (Jan-June 2022).		
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:** • 8.3 Provider Status 7.6.2 • 7.6.2.5.12 Provider Network Termination • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • CR04.01 OGM Sanctions Monitoring Procedure • OGM Reports	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Providers are checked for sanctions/exclusions as part of the initial and recredentialing procedure described in CR01. Molina also continuously monitors practitioner sanctions, exclusions, complaints and quality issues between recredentialing cycles. CR04.01 describes our process to monitor the Molina Network Providers monthly and communicate to MHI stakeholders and Health Plan Network teams to take the appropriate termination action when a Network Provider is identified as actively sanctioned or excluded by a Federal or State entity. OGM reports (Jan-March 2022) show 3 consecutive months of ongoing sanctions monitoring.		
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**
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:** • NV 2021 CR01 – Nevada State Addendum • 302B Reports	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: NV 2021 CR01 Nevada state addendum details the process when a provider is denied credentialing or not extended a provider contract where the denial is due to concerns about Provider fraud, integrity, or quality, Molina will report this to the State's Provider Enrollment Unit within fifteen (15) Calendar Days. 302B Reports included. These weekly reports document any denials or terminations.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
7. *The MCO must have written policies and procedures for credentialing and recredentialing that are in accordance with Section 7.9.6 of the Contract.* a. *The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, reviews and approves the credentialing policies and procedures.* i. *The MCO designates a credentialing committee, or other peer review body, which makes recommendations regarding credentialing decisions.*	**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	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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	**Evidence as Submitted by the MCO:** • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • CR02 Assessment and Reassessment of Organizational Providers Policy • CR02 Assessment and Reassessment of Organizational Providers Procedure • National PRC Charter • Credentialing Committee Minutes • Copy of policy submission to DHCFP for 2021	
MCO Description of Process: CR01 Policy and Procedure & CR02 Policy and Procedure submitted to DHCFP 10/1/21 for approval. 2022 policies, procedures and addendum currently in our annual review and approval process. No credentialing process changes to report. CR01 outlines Medical Director and PRC Chair responsibilities with regards to ownership and approval of credentialing policy and procedure.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While the MCO's policies were submitted to DHCFP in October 2021, the requirements of sub-element (b) were not located in the documents cited as evidence of compliance for this element. As such, HSAG recommends that the MCO update its policies or procedures to ensure staff awareness of this provision. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
8. *If the MCO delegates credentialing and recredentialing, recertification, or reappointment activities, there must be a written description of the delegated activities, and the delegate's accountability for these activities.* a. *There must be evidence that the delegate accomplished the credentialing activities.*	**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	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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	**Evidence as Submitted by the MCO:** • MHNV Delegated Services Addendum Template, 4.2 pages 8 – 12 of 23 • Teledoc Contract, Attachment H, pages 22 – 29 of 41 • VSP Contract, Attachment D, pages 36 – 47 of 73	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, due to the timing of the MCO's implementation effective date for Nevada Medicaid, annual audits of delegates' performance credentialing functions were not applicable during the time period of review. The MCO must be prepared to demonstrate implementation of these audits during future compliance reviews.		
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.i6.2.3.1; 7.6.2.3.2	**HSAG Recommended Evidence:** • Policies and procedures • Credentialing application template • Primary source verification workflow • Site review process flow • Decision notice template • Three examples of written notice of adverse credentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Practitioner Credentialing File Reviews **Evidence as Submitted by the MCO:** • CR01 Credentialing and recredentialing Practitioners Policy	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• CR01 Credentialing and recredentialing Practitioners Procedure • NV Credentialing Application • Primary Source Verification Workflow • Decision Notice Templates (approval, deferral, denial, termination)	
MCO Description of Process: Molina initially credentials practitioners in accordance with CR01 Policy & Procedure. Templates for credentialing application and decision notices included. Primary Source Verification workflow is an internal document used by our team with currently approved primary sources for verifications needed to complete credentialing.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the case file review confirmed that documentation of primary source verification (PVS) was maintained, proofs or screen shots of these verifications were not always located in the file. MCO staff members explained that the Credentials Verification Organization (CVO), which is certified by the National Committee for Quality Assurance (NCQA), did not keep images for verifications, and the checklist details all the required information in accordance with NCQA requirements. **Recommendations:** The case file review identified inconsistencies in the documentation and/or the databases queried to monitor Medicare and Medicaid sanctions imposed by the Office of Inspector General (OIG) or the State; and one of the MCO's credentialing delegates was placed on a corrective action plan (CAP) for not reviewing the Social Security Administration (SSA) Death Master File (DMF) and all published State Medicaid 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. Additionally, while the case files confirmed that verification of a provider's Drug Enforcement Administration (DEA) license occurs, the MCO should also verify a provider's license with the Nevada State Board of Pharmacy (BOP). Case files pertaining to the MCO's delegates included verification of a Nevada State BOP license, but the MCO's case files did not. HSAG will be recommending that DHCFP require verification of a Nevada State BOP license (as applicable) as a credentialing requirement in the contract. Also, while the MCO adhered to NCQA verification time limits, 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. The MCO must be prepared to demonstrate compliance with any additional credentialing provisions that may be added to its contract with DHCFP during future compliance reviews. Further, while the MCO's process was to send providers written notification of credentialing approvals, one case file did not include this notice. The MCO provided the following explanation: "There was a language change that occurred with NV letters and this 'Individual Practitioner Sample #4' got caught in between the 2 versions and this case file did not receive the proper notification. This has		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
been corrected and fixed. Since the correction was made, letters have been consistently going out [as] soon as the template was updated." As a review of denial letters was being evaluated during this compliance review, and not approval letters, HSAG will monitor the MCO's compliance with sending providers written notification of approvals during future compliance reviews. While the MCO consistently verified that providers had a current and valid license to practice in the State of Nevada, HSAG strongly recommends that the MCO conduct PSV for all State licensures, whether active or inactive. Lastly, the age bands for psychiatrists and psychologists were outdated in the MCO's policy. As such, HSAG recommends that the MCO update its policies accordingly. 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:** • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • NV Credentialing Application • Primary Source Verification Workflow • Decision Notice Templates (approval, deferral, denial, termination)	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: Molina formally recredentials its practitioners every 36 months according to procedure details and criteria outlined in CR01. As part of this recredentialing process Molina reviews performance indicators which include number of Potential Quality of Care cases, the number of member grievances against the practitioner since the last credentialing cycle, and the date of the latest claim processed. Templates for credentialing application and decision notices included. Primary Source Verification workflow is an internal document used by our team with currently approved primary sources for verifications needed to complete recredentialing.		
HSAG Findings: The case file review identified one of the files in which the provider was located in Arizona; therefore, Form NDOI-901 was inadvertently not pulled for this provider. Because the Council for Affordable Quality Healthcare (CAQH) application was used for this provider instead of Form NDOI-901, two of the disclosure questions did not fully align with the Nevada-specific questions (i.e., reasons for inability to perform the essential functions of the position, "*including any physical or behavioral health problems that may affect current ability to provide health care,"* and lack of present illegal drug use, "*including any history of chemical dependency or substance abuse."* Additionally, the MCO's case files included a "*Recredentialing Performance Review*" form which included the *"# of Potential Quality of Care Cases,*" *"# of Member Complaints,*" *"# of Dirty Office Complaints,*" and "*Date of last claims paid.*" However, this does not fully align with DHCFP's contract provision that requires the recredentialing process to include a review of data from all of the following: member grievances and appeals, quality reviews, utilization management, and member satisfaction surveys. After the site review, the MCO explained that the last claim paid date confirms if the provider is actively seeing the MCO's members, and that no recent claims activity may indicate that the provider is not needed in the network. While this may be an important aspect for the MCO to consider, it is not an indicator that evaluates the performance of providers using utilization management data (e.g., over- and underutilization of services). Further, the MCO is required to consider the results of member satisfaction surveys. If these results are not linked to a specific provider, the MCO should have this documented to confirm it considered this activity, but no provider-specific results were available. Lastly, performance reviews were included in the case files pertaining to the MCO's delegates, but the performance reviews did not fully align with the data elements required to be reviewed during the recredentialing process according to the MCO's contract with DHCFP. The MCO explained that the documents demonstrate how a hospital system reviews practitioner information at recredentialing. If any areas are identified for the practitioner, the MCO would provide these data to the delegate to include in the delegate's review. If there was no data to provide, it would not be included by the delegate. However, the MCO did not clearly demonstrate this process during the site review, and it should still be documented in the recredentialing file. Further, some of the performance review information in the delegate's case files included data collected after the provider was recredentialed, confirming that this information could not have been considered at the time of recredentialing. A case/procedure summary was also included in the case files; however, the date span for these data ended five to six months prior to the provider's recredentialing date. The intent of the requirement is to review performance data that are available during the entire three-year period between recredentialing cycles.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Of note, while the MCO was new to the Nevada Medicaid managed care program, the MCO reported those practitioners who were being recredentialed for another program or delegate as "recredentialed." As such, the MCO's recredentialing processes were evaluated as part of this compliance review.		
Required Actions: The MCO must comply with all individual practitioner recredentialing requirements as specified in 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:** • CR02 Assessment and Reassessment of Organizational Providers Policy • CR02 Assessment and Reassessment of Organizational Providers • Decision Notice Templates (approval, deferral, denial, termination	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Molina initially credentials providers in accordance with CR02 Policy & Procedure. Templates for decision notices included.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** The case file review did not consistently demonstrate that a site review was completed, or that the results of the site review were documented in the credentialing file (for those providers not accredited). Due to the challenges of the pandemic, HSAG did not consider this observation as a deficiency. However, moving forward, the MCO must ensure that each organizational provider being credentialed is accredited or has the results of an on-site survey documented in the case file. The MCO must be prepared to demonstrate compliance with this provision during future compliance reviews or the MCO will be assigned a score of *Not Met*. Additionally, one case file identified a practitioner whose name surfaced as a result on the Medicare and		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Medicaid exclusions/sanctions search. While MCO staff members confirmed that this practitioner was individually credentialed with the MCO, the MCO should have documented that the search result was confirmed to not be the practitioner in question within the organizational provider's credentialing file. Further, the case file review identified some inconsistencies in screening for Medicare and Medicaid exclusions/sanctions for individuals listed on the application and/or the disclosure of ownership and control interest form. This was not a specific scoring element on the file review tool; however, HSAG recommends that the MCO enhance processes to ensure all practitioners or other individuals, or associated organizations identified on an application and/or the disclosure of ownership and control interest form, are properly screened either through the credentialing process or the contracting process. Also, while the MCO's process was to send providers written notification of credentialing approvals, one case file did not include this notice. The MCO provided the following explanation: "There was a language change that occurred with NV letters and this "Organization Sample #1" got caught in between the 2 versions and this case file did not receive the proper notification. This has been corrected and fixed. Since the correction was made, letters have been consistently going out [as] soon as the template was updated." HSAG will monitor the MCO's compliance with sending providers written notification of approvals during future compliance reviews. Lasty, while the MCO conducted secondary source verification of licensure for organizational providers in accordance with NCQA credentialing requirements, HSAG recommends that the MCO consider revising policy to conduct PSV. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		
12. The MCO complies with organizational recredentialing requirements as specified in the Organizational Credentialing and Recredentialing File Review Tool. 42 CFR §438.214	**HSAG Recommended Evidence:** • Policies and procedures • Decision notice template • Three examples of written notice of adverse recredentialing decision (if samples selected for file review do not include any denials) • HSAG will also use the results of the Organizational Recredentialing File Reviews **Evidence as Submitted by the MCO:** • CR02 Assessment and Reassessment of Organizational Providers Policy • CR02 Assessment and Reassessment of Organizational Providers	☐ Met ☐ Not Met ☒ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Decision Notice Templates (approval, deferral, denial, termination)	
MCO Description of Process: Molina formally recredentials its providers every 36 months according to procedure details and criteria outlined in CR02. Templates for decision notices included.		
HSAG Findings: As the MCO has not recredentialed any organizational providers during the time period of review, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with organizational recredentialing will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard VIII—Provider Selection						
Met	=	9	X	1	=	9
Not Met	=	2	X	0	=	0
Not Applicable	=	1				
Total Applicable	=	11	Total Score		=	9
Total Score ÷ Total Applicable					=	82%

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:
	1.a.
	• See MHNV HP-03 - Privacy and Confidentiality of PHI; Section II & III, Pages 1 to 9.
	• See MHNV HP-16 - Confidentiality Information; Section II & III, Pages 1 to 4.
	• New MHNV Employees and other Workforce Members must sign the Workforce Confidentiality Agreement at the time of employment with Molina.
	  • MHNV Employees and other Workforce Members have to annually read, accept & sign the Workforce Confidentiality Agreement.
	  • See MHNV Workforce Confidentiality Agreement.
	• See Training Overview Document and attached Training Materials Attachment.
	• See MHNV HP- 44 - Privacy and Security Workforce Training, entire document.
	• See MHNV HP-45 - Sanctioning of Workforce, entire document.
		☒ Met
		☐ Not Met
		☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	1.b. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III, B, Pages 3 to 6; and Section III, D, Page 8. • See Provider Contract Template, Article 2, Page 4, and Attachment D, Pages 19 to 22. • See Provider Manual-NV Medicaid, HIPAA Section, Pages 83 to 88. • See MHNV HP-25 – Uses and Disclosures of PHI – Verification of Requestor of PHI, entire document. 1.c. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III.A, 4, Page 2, Section B, 1, Page 3. • See MHNV HP 04 - Uses and Disclosures of PHI-Authorization Required; Page 1, Section II. • See MHNV Workforce Confidentiality Agreement.	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
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.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Business associate agreement template • Delegate agreement/contract	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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	• HIPAA incident tracking mechanism **Evidence as Submitted by the MCO:** 2. a. to f. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III.B.3, Page 3. • See MHNV HP 21- Business Associates Contracting; Section III, Pages 1 to 4. • See Business Associate Agreement Template, Section 3 & Section 4,4.1, Pages 3 to 5. • See HIPAA Incident Overview Document. • See Training Overview Document and attached Training Materials Attachment. • HIPAA Incidents are tracked in the Compliance HIPAA Management Program (CHAMP) system. See HIPAA Incident Overview Document.	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
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.	**HSAG Recommended Evidence:** • Policies and procedures • Workflow for processing requests • Training materials • Business associate agreement template **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.502(a)(2-4)	3.a. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III.B. 2.a, Page 3. • See MHNV HP 12 - Member's Right to Accounting of Disclosures of PHI, entire document. • See MHNV HP 13 - Member's Right of Access to PHI_PII, entire document. • See Business Associate Agreement Template, Section 4, 4.7 & 4.8, Pages 4 & 5. • See MHNV HP 21- Business Associates Contracting; Section III, B, Page 2. 3.b. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III.B. 2.b, Page 3. • See Business Associate Agreement Template, Section 4.10, Page 5. • See MHNV HP 21- Business Associates Contracting; Section III, B, 8. Page 2. • See Training Overview Document and attached Training Materials Attachment.	
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**
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:** • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section II.B, page 1, and Section III, B, 6, Page 5. • See MHNV HP 23 - Uses & Disclosures of PHI_PII Minimum Necessary, Section II, A & B, Page 1 & Page 2. • See Training Materials Attachment, HIPAA 101 Privacy Training -New Hire, Pages 9 to 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.		
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.	**HSAG Recommended Evidence:** • Policies and procedures • Training materials **Evidence as Submitted by the MCO:** 5.a-f. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III, B, 6.b, Page 5. • See MHNV HP 23 - Uses & Disclosures of PHI_PII Minimum Necessary, Section II, B, 1, Page 2.	☒ Met ☐ Not Met ☐ NA

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.502(b)(2)	• See Training Materials Attachment, HIPAA 101 Privacy Training -New Hire, Pages 9 to 10.	
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 a use or disclosure of PHI, the covered entity must provide the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4)	**HSAG Recommended Evidence:** • Policies and procedures • Training materials • Authorization for use and disclosure form **Evidence as Submitted by the MCO:** 6.a. • See MHNV HP-03 - Privacy and Confidentiality of PHI; Section III, B,1, Page 3. • See MHNV HP 04 - Uses & Disclosures of PHI: Authorization Required, Section II & III, Pages 1 to 6. • Authorization for Use and Disclosure Form – See NV Request Form Template-Accounting of Disclosures of PHI. • See Training Materials Attachment, HIPAA 201- Healthcare Services, Page 4-5.	☒ 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**
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:** 7. • See MHNV HP 15 - The Member's Rights to Request Privacy Protections, Section II & III A, Pages 1 & 2. • Request Form Template : See NV Request Form Template – Special Privacy Protections of PHI. • See Nevada PHI Request Workflow 2022. • See Training Materials Attachment, HIPAA 201 – Member and Provider Contact Center, Page 4. • Examples & Tracking: None received for 1/1/2022 to 7/15/2022. See NV – Special Privacy Protection Request List.	☒ 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**
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:** 8.a. • See MHNV HP 13 -Member's Rights of Access to PHI and PII, Section III, 6, Page 2. • See Nevada PHI Request Workflow 2022. • Request Form Template: See NV Request Form Template – Access to PHI. 8.b. • See Member's Rights of Access to PHI and PII – HP-13, Section III, 6.b, Page 3. • See Training Materials Attachment, HIPAA 201 – Member and Provider Contact Center, Page 7. • Examples & Tracking: One request received for 1/1/2022 to 7/15/2022. See Example and Tracking- NV-Access to PHI Request List.	☒ 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**
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:** 9.a. • See MHNV HP 14 - Member's Right to Amend PHI & PII, Section II and Section III, 5, Pages 1 to 4. • Request Form Template: See NV Request Form Template – Amendment of PHI Request. • See Nevada PHI Request Workflow 2022. • See Training Materials Attachment, See HIPAA 201 – Healthcare Services, Page 5. • Examples & Tracking: None received for 1/1/2022 to 7/15/2022. See NV- Amendment Request List.	☒ 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**
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. 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	**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:** 10.a. • See MHNV HP 12 - Member's Right to Accounting of Disclosures of PHI, Section III, C, Page 2. • See Nevada PHI Request Workflow 2022. • Request Form Template: See NV Request Form Template – Accounting of Disclosures of PHI. 10.b. • See MHNV HP 12 - Member's Right to Accounting of Disclosures of PHI, Section III, E, Page 3. • See Training Materials Attachment HIPAA 201 – Healthcare Services, Page 12. • Examples & Tracking: None received for 1/1/2022 to 7/15/2022. See NV – Accounting of Disclosure Request List.	☒ 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**
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:** 11.a. • See MHNV HP 11 - Notice of Privacy Practices – Provision & Content, Section III, B,1, on Page 2. 11.b. • See MHNV HP 11 - Notice of Privacy Practices – Provision + Content, Section III, 2 a, on Page 2. • See Notice of Privacy Practices-NV, Page 3. • Notice of Privacy Practices – NV (also posted on Molina Healthcare of Nevada, Inc., website. • See Training Materials Attachment.	☒ 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's Notice of Privacy Practices did not specifically include a statement for "The right of an individual, including an individual who has agreed to receive the notice electronically in accordance with paragraph (c)(3) of this section [45 CFR §164.520*],* to obtain a paper copy of the notice from the covered entity upon request," the MCO's notice included the right of a member to get a paper copy of the notice by calling member services. During the site review, MCO staff members explained that they have opted as an organization to not provide members with a Notice of Privacy Practices electronically and that all members receive a paper copy of the notice upon enrollment and in accordance with the time frames required under federal rule. Although the MCO received a *Met* score for this element because it does not provide notices electronically through email to members, HSAG		

Standard IX—Confidentiality		
Requirement	**Supporting Documentation**	**Score**
recommends that the MCO update its policy to explain why the Notice of Privacy Practices does not specifically include the member's right to receive a paper copy of the notice on request when the member has agreed to receive the notice electronically. HSAG also recommends that the MCO ensure its Notice of Privacy Practices is updated with the specific right under 45 CFR §164.520(b)(1)(iv)(F) if the Nevada health plan determines that it will provide notices to its members electronically with the member's agreement. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard IX—Confidentiality						
Met	=	11	X	1	=	11
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	11	**Total Score**		=	11
Total Score ÷ Total Applicable					=	100%

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:** • X.1 Brennon Jackson_CA_AZ_NV_Org Chart 01052022 • X.1 Job Description - A&G Clerk • X.1 Job Description - A&G Associate Specialist • X.1 Job Description - A&G Specialist • X.1 Job Description - A&G Lead • X,1 Job Description A&G Manager • X.1 Job Description – Nevada Appeals Nurse LVN • X. 1 NV Training Curriculum – due 11-21-22	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: Molina has Appeals & Grievance staff dedicated to handling the Nevada Member and Provider Appeals, Grievances and Disputes.		
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	**HSAG Recommended Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCO:** • X.2 Member Grievance Process (Medicaid) – pg. 1 Section 1 • X.2 2630 NevadaMedicaidHandbook_bnm_FNL pg 62	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an 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: The Grievance definition is included in the Grievance Policy and Member Handbook.		
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:** • X.3 Member Grievance Process (Medicaid) – pg.2 Section B.a • X.3 NevadaMedicaidHandbook_bnm_FNL pg 60 & 62 • X.3 Mbr GrievAckConsent Req – approved by DHCFP 1-4-22	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Grievance Process describes who may file a grievance.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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:** • Member Grievance Process (Medicaid) – pg. 2 & 3 • NV Medicaid Member Handbook – pg 60 – 62	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Grievance Process describes how to file a grievance.		
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:** • X.5 Member Grievance Process (Medicaid) – pg. 2 Sections B, C..c, & D • X.5 Letter- Mbr Grievance Acknowledgement Letter – approved by DHCFP 1-4-22 • X.5 Letter – Mbr PQOC Grievance Acknowledgement Letter – approved by DHCFP 1-4-22	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Grievance Process explains that grievances must be acknowledged.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO acknowledged grievances in a timely manner in accordance with the Member Grievance Process (Medicaid) policy, the written acknowledgement letters did not include a description of the grievance filed by the member. To ensure members are aware of the grievance being acknowledged, HSAG strongly recommends that the MCO's grievance acknowledgment letter templates be updated to include space for staff members to document a summary of the grievance filed. The MCO's implementation of this recommendation will be evaluated for compliance during future compliance reviews.		
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:** • X.6 Member Grievance Process (Medicaid) – pg. 3 &4 • X.6 NV Medicaid Member Handbook – pg 61	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Grievance Process explains that cases will be reviewed by a different decision maker at each level of review.		
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:** • X.7 Member Grievance Process (Medicaid) – pg. 2-4 • X.7 Letter – Mbr Grievance Resolution Letter – approved by DHCFP 1-4-22 • X.7 Letter – Mbr PQOC Grievance Resolution Letter – approved by DHCFP 1-4-22 • X.7 Letter – Mbr Griev Unable to Reach – approved by DHCFP 1-4-22 • X.7 NV Medicaid Member Handbook pg 62	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The Grievance Process explains the resolution timeframe and how it should be delivered to the member.		
HSAG Findings: Although all grievances were reviewed and resolved, and written notification was sent to members within 90 days for all case files reviewed, the grievance resolution notices did not include taglines in conspicuously visible font as required by 42 CFR §438.10. **Recommendations:** Grievance resolution letters reviewed as part of the case file review included acronyms that were not spelled out and/or contained typographical or grammatical errors; therefore, HSAG recommends that the MCO enhance its existing process to quality check letters prior to mailing to members. Additionally, although the grievance resolution letters were dated, HSAG recommends that the MCO include the date of resolution within the body of the letter. Further, the Medicaid Grievance Process (Medicaid) policy included conflicting time frames regarding when grievances should be resolved. Although the MCO confirmed that the policy is to resolve grievances within 90 days, HSAG recommends the MCO update its policy and member materials to ensure there are no conflicting time frames (i.e., 30 days versus 90 days). Finally, although the MCO made one attempt to outreach to members to notify them of the grievance resolution as indicated through the case file review, the MCO indicated that it expects staff members to make at least two attempts to notify the member of the grievance resolution orally. As such, HSAG recommends that the MCO ensure its staff members comply with these expectations and update its policy to clearly indicate that two attempts will be made to notify the member orally of the grievance resolution. Implementation		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
of these recommendations 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 ensure the written notice of resolution meets the standards described at 42 CFR §438.10 and includes taglines in the prevalent non-English languages spoken in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free teletypewriter (TTY)/telecommunications device for the deaf (TTD) telephone number of the MCO's member/customer service unit.		
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:** • X.8 Member Grievance Process (Medicaid) – pgs. 3-4 • X.8 Mbr Grievance Extension Letter – approved by DHCFP 1-4-22 • X.8 NV Medicaid Member Handbook – page 62	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Grievance Process describes the extension process. Molina has not had any cases requesting extensions.		
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 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.	**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)	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.408(c)(2-3) 42 CFR §438.228 Contract 7.8.10.9.3	• Grievance extension template letter • HSAG will also use the results of the Grievance File Review **Evidence as Submitted by the MCO:** • X.9 Member Grievance Process (Medicaid) – pgs. 4 • X.9 Letter – Mbr Grievance Extension Letter – approved by DHCFP 1-4-22 • X.9 NV Medicaid Member Handbook – page 62	
MCO Description of Process: The Grievance process describes the extension process. Molina has not had any cases requesting extensions.		
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 grievance resolution time frame extensions were applied during the time period under review.		
Required Actions: None.		
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:** • X.10 Member Appeal Process (Medicaid) – pg. 1 & 2 • X.10 NV Medicaid Member Handbook – pgs 62 & 63	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal definition is included in the Appeals Process and Member Handbook.		
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**
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:** • X.11 Member Appeal Process (Medicaid) – pg. 5 & 10 • X.11 NV Medicaid Member Handbook – pg 62-64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains there is one level for members.		
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 an 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:** • X.12 Member Appeal Process (Medicaid) – pg. 5 • X.12 NV Medicaid Member Handbook – pg 61 and 64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeals Process describes the Expedited Review Process including there is no punitive actions taken against a provider that requests an Expedited Appeal.		

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.		
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:** • X.13 Member Appeal Process (Medicaid) – pg. 5 & 9 • X.13 NV Medicaid Member Handbook – pg 63 & 65 • X.13 NABD Letter – Draft EN_V4	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeals Process explains the member has 60 calendar days to file an Appeal after they receive an Adverse Benefit Determination.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
14. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. b. *If an appeal is filed orally, the MCO is required to document the contact for tracking purposes and to establish the earliest date of receipt. The MCO must not require the member to submit a written appeal after making an oral appeal.*	**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:** • X.14 Member Appeals Process (Medicaid) – pg. . 2, 5 & 11 • X.14 NV Medicaid Member Handbook – pg 62-63	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §438.228 Contract 7.8.10.6.1	• X.14 Letter – Mbr Standard Expedited AOR Required – approved by DHCFP 1-4-22 • X.14 MbrStanExpAppAckConsentReq – approved by DHCFP 1-5-22	
MCO Description of Process: The Appeal Process explains how to file an Appeal.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** Although the MCO provided evidence to support that it obtains members' written consent when appeals are being filed on their behalf, its Member Appeal Process (Medicaid) policy indicates, *"…provider must first obtain the member's written permission with the exception of an expedited appeal*." Therefore, HSAG strongly recommends that the MCO remove the language stipulating that there are exceptions to obtaining written permission as this does not align with federal rule. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
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)	**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:** • X.15 Member Appeal Process (Medicaid) – pgs. 3-7 • X.15 NV Medicaid Member Handbook – pg 64 • X.15 Letter – Mbr Exp Appeal Denial Letter – approved by DHCFP 1-4-22	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.5.3		
MCO Description of Process: The Appeal Process explains how a denied request for an Expedited Appeal is handled through the Standard Appeals Process.		
HSAG Findings: The MCO's Member Appeal Process (Medicaid) policy appropriately indicated that if an expedited appeal request does not meet expedited criteria, the coordinator will provide immediate oral notice to the member and follow up within two calendar days with a written notice of the denial to expedite the appeal. The Expedited Appeal Denied template letter also included appropriate language to meet the intent of the requirements under this element. However, as indicated through the case file review, MCO staff members did not follow the MCO's process and provide members with oral and written notice of the decision to process the appeal under the standard time frame. After the site review, the MCO confirmed that the appeals included as part of the file review were mishandled by the assigned coordinator.		
Required Actions: If the MCO denies a request for expedited resolution of an appeal, it must make reasonable efforts to give the member prompt oral notice of the delay; and within two calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.		
16. The MCO must acknowledge receipt of each appeal. 42 CFR §438.406(b)(1) 42 CFR §438.228 Contract 7.8.10.10.2	**HSAG Recommended Evidence:** • Policies and procedures • Acknowledgement template notice and/or script • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • X.16 Member Appeal Process (Medicaid) – pg. 2, 3 & 6 • X.16 Letter – Mbr Standard Appeal Acknowledgement letter – approved by DHCFP 1-4-22 • X.16 Letter – Mbr Standard Appeal Acknowledgement Letter – approved by DHCFP 1-4-22	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains that appeals must be acknowledged.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Multiple acknowledgement letters reviewed as part of the case file review did not include the name of the service being appealed, or there were spacing issues. As such, HSAG strongly recommends that the MCO quality check its appeal acknowledgement letters prior to mailing to members and ensure that the name of the service being appealed is included as part of the letter to the member. Implementation of this recommendation will be evaluated during future compliance reviews.		
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) 42 CFR §438.228 Contract 7.8.10.10.3; 7.8.10.10.4; 7.8.10.10.4.1; 7.8.10.10.4.3	**HSAG Recommended Evidence:** • Policies and procedures • Organizational chart • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • X.17 Member Appeal Process (Medicaid) – pg. 3, 5 & 6 • X.17 NV Medicaid Member Handbook – pg 61	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains that cases will be reviewed by a different decision maker at each level of review.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
18. The MCO must provide that oral inquiries seeking to appeal an ABD are treated as appeals. 42 CFR §438.406(b)(3) 42 CFR §438.228 Contract 7.8.10.10.5	**HSAG Recommended Evidence:** • Policies and procedures • HSAG will also use the results of the Appeal File Review **Evidence as Submitted by the MCO:** • X.18 Member Appeal Process (Medicaid) – pg. 6 • X.18 NV Medicaid Member Handbook – pg 63	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains how oral inquiries seeking appeals are handled.		
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:** • X.19 Member Appeal Process (Medicaid) – pg. 6 • X.19 NV Medicaid Member Handbook – pg 63 & 64 • X.19 NV Mbr Additional Information Needed – approved by DHCFP 5-13-22 • X.19 NV NABD Letter – Draft EN_V4	☐ Met ☒ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains that Members have an opportunity to present additional information pertaining to their case.		
HSAG Findings: The Member Appeal Process (Medicaid) policy stipulated the requirements of this element. Additionally, a copy of the member handbook was provided as evidence to demonstrate that members were provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Although the member handbook indicated, "you have the opportunity to present Molina with evidence of the facts or law about your case, in person or in writing," the member handbook is not a substitute to providing this information at the time of an adverse		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
benefit determination (ABD) and/or during the appeal process. Additionally, the member handbook did not inform members of the limited time available for this opportunity sufficiently in advance of the resolution time frame for expedited appeals. Further, although the MCO's ABD template was provided as evidence, it also does not adequately inform members of this opportunity. **Recommendations:** To ensure members are notified in a timely manner of their right to present evidence and testimony and make legal and factual arguments for their appeal, HSAG recommends the MCO consider providing this information orally to members when contacting them about their appeal and documenting the discussion within the appeal call notes, adding language to the ABD notice, and/or adding language to the appeal acknowledgement letters. For expedited appeals, HSAG also recommends the MCO should consider discussing this opportunity with the member at the time the appeal is being filed and documenting the discussion in the appeal call notes. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: The MCO must provide members a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. 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.		
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:** • X.20 Member Appeal Process (Medicaid) – pg. 6 • X.20 NV Medicaid Member Handbook – pg 61, 62 & 64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains that Molina must provide the Member all relevant documentation to their case, upon the Member's request, free of charge.		
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**
Resolution and Notification of Appeals		
21. The MCO must resolve standard appeals and send *written* notice to the affected parties as expeditiously as the member's health condition requires, but *no later than thirty (30) calendar days* from the day the MCO receives the appeal. 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §438.228 Contract 7.8.10.9.1.2; 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:** • X.21 Member Appeal Process (Medicaid) – pg. 3, 5 & 6 • X.21 NV Mbr Standard_Non-Clinical Appeal Resolution Letter (Overturn) • X.21 NV Mbr Standard_Non-Clinical Appeal Resolution Letter (Uphold) • X.21 NV Medicaid Member Handbook – pg 63 & 64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains that all Appeal Resolutions must be sent to the Member in writing.		
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:** • X.22 Member Appeal Process (Medicaid) – pg. 3 & 6 • X.22 NV Medicaid Member Handbook –pg 64	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• X.22 Letter – Mbr Standard Expedited Appeal Resolution Letter (Overturn) • X.22 Letter- Mbr Standard Expedited Appeal Resolution Letter (Upheld)	
MCO Description of Process: The Appeal Process explains that resolutions for Expedited Appeals must be provided to the Member in writing and an attempt should be made to provide the resolution orally too.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** As indicated through the case file review, expedited appeals were resolved and timely written notification was provided. Additionally, MCO staff members demonstrated that one call attempt was made to notify members orally of the appeal resolution. However, during the site review, MCO staff members indicated that the expectation is for staff members to make at least two call attempts to notify members orally of the appeal resolution. As such, HSAG strongly recommends that the MCO's policy be updated to include the expectations for making a good faith effort to notify members orally of the resolution and ensure that MCO staff members comply with these expectations. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
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:** • X.23 Member Appeal Process (Medicaid) – pgs. 5-6 • X.23 NV Medicaid Member Handbook – pg 63 & 64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process describes the extension process. Molina has not had any cases requesting extensions.		
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.		

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.408(c)(2) 42 CFR §438.228 Contract 7.8.10.9.3	**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:** • X.24 Member Appeal Process (Medicaid) – pgs. 4 &5 • X.24 Letter – Mbr Standard Expedited Appeal Extension – approved by DHCFP 1-4-22 • X.24 NV Medicaid Member Handbook – pg 63 & 64	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process describes the extension process. Molina has not had any cases requesting extensions.		
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.		
25. In the case that the MCO fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCO's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i)	**HSAG Recommended Evidence:** • Policies and procedures • Tracking documentation • Member materials, such as the member handbook • Three examples of an appeal not resolved timely (written notice to the member must be included) • HSAG will also use the results of the Appeal File Review	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 Contract 7.8.10.9.4	**Evidence as Submitted by the MCO:** • X.25 Member Appeal Process (Medicaid) – pg. 5, 7 & 10 • X.25 NV Medicaid Member Handbook – pg 66	
MCO Description of Process: The Appeal Process explains the next step should Molina exceed the resolution timeframe.		
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 resolution time frame extensions were met during the time period under review.		
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:** • X.26 Member Appeal Process (Medicaid) – pg. 3, 7, 9-10 • X.26 Mbr Standard Non-Clinical Appeal Resolution Letter (Overturn) – approved by DHCFP 1-4-22 • X.26 Mbr Standard Non-Clinical Appeal Resolution Letter (Upheld) – approved by DHCFP 1-4-22 • X.26 Mbr Standard Expedited Appeal Resolution Letter (Overturn) – approved by DHCFP 1-4-22 • X.26 Mbr Standard Expedited Appeal Resolution Letter (Upheld) – approved by DHCFP 1-4-22 • X.26 NV Medicaid Member Handbook – pg 3-6, 22,43,60	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The Appeal Process describes the resolution that should be given to the member and the next steps if the decision is unfavorable for the member.		
HSAG Findings: One appeal resolution letter reviewed as part of the case file review indicated that the appeal was partially approved; however, the notice did not include SFH rights or information about continuing benefits. After the site review, MCO staff members explained that there was no denial, and that if a partial denial of services did occur, the member would receive two notices, including a notice of denial that would contain SFH rights and information about continuation of benefits. However, because the appeal resolution notice reviewed as part of the case file review indicated that "we have PARTIALLY APPROVED your treatment," this confirms that services were also partially denied. In review of the appeal resolution notice, services were requested for a period of eight months; however, the MCO's appeal resolution letter indicated that "we could not approve all the dates asked." Please also refer to findings under Element 7 regarding noncompliance with tagline requirements under 42 CFR §438.10. **Recommendations:** Although the MCO indicated that the date of the letter is the appeal resolution date, HSAG strongly recommends that the MCO consider adding the appeal resolution date in the body of the resolution notice. Further, most appeal resolution letters reviewed as part of the case file review contained minor typographical and/or grammatical issues, such as incomplete sentences or shortened words (e.g., meds). Therefore, HSAG recommends that MCO staff members develop a quality assurance process, or enhance the existing process, for reviewing resolution letters prior to being sent to members. Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution must also include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member, the notice must also include the right to request a SFH, and how to do so; the right to request and receive benefits while the hearing is pending, and how to make the request; and 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.		
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:** • X.27 Member Appeal Process (Medicaid) – pg. 3 & 7	☐ Met ☒ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The Appeal Process explains that resolutions for Standard and Expedited Appeals must be provided to the Member in writing and an attempt should be made to provide the resolution orally too		
HSAG Findings: One appeal reviewed as part of the case file review did not demonstrate that attempts were made to provide the member with oral notification of the resolution. Additionally, although the MCO indicated that the expectation is for staff members to make at least two outreach attempts, only one of the appeals reviewed as part of the case file review supported that staff members were making at least two outreach attempts to notify members orally of the appeal resolution.		
Required Actions: 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.		
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:** • X.28 Member Appeal Process (Medicaid) – pgs. 5 & 7 • X.28 Mbr Standard Non-Clinical Appeal Resolution Letter (Upheld) – approved by DHCFP 1-4-22 • X.28 Mbr Standard Expedited Appeal Resolution Letter (Upheld) – approved by DHCFP 1-4-22 • X.28 NV NABD Letter-Draft EN_V4 • X.28 NV Medicaid Member Handbook – pg 66	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains the Member's next step after completing the one internal level of appeal.		
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**
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:** • X.29 Member Appeal Process (Medicaid) – pgs. 10 • X.29 Member Standard_Expedited Appeal Resolution Letter Uphold (9/9/21) • X.29 NV Mbr Standard_Non Clinical Appeal Resolution Letter (Uphold) – approved by DHCFP 1-4-22 • X.29 NV Medicaid Member Handbook – pg 66 • X.29 NV NABD Letter-Draft EN_V4	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains how a member can submit a request for a State Fair Hearing. Molina has not had any State Fair Hearing cases.		
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:** • X.30 Member Appeal Process (Medicaid) – pgs. 9 • X.30 NV Medicaid Member Handbook – pg 65 • X.30 NV NABD Letter-Draft EN_V4 • X.30 Member Standard_Expedited Appeal Resolution Letter Uphold (9/9/21) • X.30 NV Mbr Standard Non Clinical Appeal Resolution Letter (Uphold) – approved by DHCFP 1-4-22	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains when Molina must continue the member's benefits. Molina has not had any State Fair Hearing cases.		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, MCO staff members confirmed there were no requests for continuation of benefits during the time period under review.		
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:** • X.31 Member Appeal Process (Medicaid) – pgs. 9 • X.31 NV Medicaid Member Handbook – pg 65 • X.31 NV NABD Letter-Draft EN_V4	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains how the member can request for their benefits to continue while they go through the appeal or State Fair Hearing process. Molina has not had any State Fair Hearing cases.		
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:** • X.32 Member Appeal Process (Medicaid) – pgs. 7 & 9 • X.32 NV Medicaid Member Handbook – pg 66 & 67 • X.32 NV NABD Letter-Draft EN_V4	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process: The Appeal Process explains the option of cost recovery if the appeal decision is adverse for the member. Molina has not had any State Fair Hearing cases.		
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:** • X.33 Member Appeal Process (Medicaid) – pgs. 4 & 10 • X.33 NV Medicaid Member Handbook – pg 66 & 67	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains how Molina should handle disputed services if original denial is overturned. Molina has not had any State Fair Hearing cases		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
34. If the MCO or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, *the MCO must pay for those services.* 42 CFR §438.424(b) 42 CFR §438.228 Contract 7.8.10.8.4	**HSAG Recommended Evidence:** • Policies and procedures • Three examples of a SFH reversal with corresponding authorization of services **Evidence as Submitted by the MCO:** • X.34 Member Appeal Process (Medicaid) – pgs. 10	☒ Met ☐ Not Met ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• X.34 NV Medicaid Member Handbook – pg 67	
MCO Description of Process: The Appeal Process explains how Molina must pay for services if the original denial is overturned. Molina has not had any State Fair Hearing cases.		
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:** • X.35 NV Medicaid Member Handbook – pg 3-5, 60	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Member Handbook provides resources available to Members to help them participate/communicate in the grievance and appeal 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:** • X.36 2022_ NV_ Medicaid_ Provider_ Manual_ 072022 _RA – pgs. 116-119	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeals and Grievance Processes are described in the Provider Manual and has all contact information for mail, fax, phone numbers to reach the Appeals and Grievance Department.		
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:** • X.37 Member Appeal Process (Medicaid) – pg. 10	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Appeal Process explains all parties that must be included in appeals or State Fair Hearings. Molina has not had any State Fair Hearing cases.		

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.		
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:** • X.38 Member Grievance Process (Medicaid) – pgs. 6 & 7 • X.38 Member Appeal Process (Medicaid) – pg. 11	☒ Met ☐ Not Met ☐ NA
MCO Description of Process: The Grievance and Appeals Processes both explain record retention for all cases.		
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		=	38
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:** • XI_1_P_P_DO001_CR: page 2, Section II; page 6, Section X • XI_1_P_P_DO006_UM: page 2, Section II; page 5, Section X • XI_1_DO_Prgm_Dsc: preamble page 1, Section II pages 3-4, Section III pages 4 – 5, and Section IV page 5 • XI_1_MHNV_ST_Reg_Add: Article 2.1, page 3 of 23 • XI_1-7_VSP_Contract: Attachment D, 2.1 pages 37-38 of 73 • XI_1-7_TD_Contract: Attachment H, 2.1, page 22 of 71. • XI_1-7_NCH_Contract: Attachment 4-A-D.1, page 23 of 41 • XI_1_NCH_Subcontract Approval from DHCFP • XI_NCH_Subcontract Amendment No.1 Approval from DHCFP Proof • XI_1_Subcontractor Checklist_NCH • XI_1_Subcontractor Checklist_Teledoc	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• XI_1_Subcontractor Checklist_VSP • XI_1_Teladoc_Subcontract Approval from DHCFP • XI_1_Teladoc_Subcontract Approval from DHCFP_v2 • XI_1_VSP_Subcontract Approval from DHCFP • XI_1_CVS - Pre-delegation NV 12.22.21 • XI_1_CVS Subcontract Approval from DHCFP • XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, #6, page 547 of 554 • XI_1_NV CVS Subcontractor Checklist Template	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, MCO staff members indicated that they have not received a request from DHCFP for the information described in sub-element (c). **Recommendations:** The Medicaid regulatory requirements attachment included the following provision: "*Within thirty-five (35) Calendar Days of the date of request, Subcontractor must provide full and complete information about its ownership if Subcontractor and Client have had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the twelve-month (12-month) period ending on the date of request as required by 42 CFR 455.105…*" However, HSAG recommends that the MCO consider reducing the time frame standard for its subcontractors to provide this information to the MCO to ensure adequate time for the MCO to meet its 35-calendar-day reporting requirement to DHCFP. Additionally, HSAG recommends the MCO consider adding this requirement to a policy, procedure, or workflow to ensure staff awareness of this provision. Implementation of these recommendations 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.	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:**	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
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	• XI_2_MHNV_ST_Reg_Add: 2.6 page 5 of 23, Article 4 pages 4 – 23 of 23 • XI_2_DSA_Add_Tmp: 2.1 page 3 of 23 • XI_2_DSA_Add_Tmp: Article 3 pages 6 – 7 of 23 • XI_1-7_VSP_Contract: Attachment D, Article 4, pages 42 – 53 of 73 • XI_1-7_VSP_Contract: Attachment D, 2.1 pages 37 of 73 • XI_1-7_VSP_Contract: Attachment D, 3.2 Pages 41- 42 of 73 • XI_1-7_TD_Contract: Attachment H, Article 4, pages 26-30 of 41 • XI_1-7_TD_Contract: Attachment H, 2.1 pages 23 of 41 • XI_1-7_TD_Contract: Attachment H, 3.2 Pages 25-26 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, Attachment A-2-D:1,2, pages 29 – 35 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, Item 1, page 23 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, 1.14, page 27 of 41 • XI_2_MHNV_ST_Reg_Add: A-13, 1.7, page 2 of 7 • XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, Exhibit 9, page 118-124 of 554	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** For one delegate, the delegated services addendum included a care management and disease management reporting requirement. However, after the site review, the MCO clarified that these reports are not required from this delegate and are outside of the scope of services the delegate is providing. Additionally, for one delegate, the written arrangement did not outline specific reporting responsibilities and instead the delegate was required to comply with the reporting requirements required by DHCFP. As such, HSAG recommends that the MCO enhance processes to ensure its written		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
arrangements with all delegates clearly identify all specific reporting requirements and are catered toward each delegate's specific scope of services for Nevada Medicaid. The MCO should be prepared to demonstrate implementation of HSAG's recommendations during future compliance reviews.		
Required Actions: None.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, *including but not limited to the provisions related to confidentiality, HIPAA requirements, insurance requirements, and record retention.* 42 CFR §438.230(c)(2) Contract 7.2.2.7	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • XI_3_MHNV_ST_Reg_Add: A-13, 1.1, page 1 of 7, 1.13 page 3 of 7, Section 2 General Requirements pages 5 – 7 • XI_3_DSA_Add_Tmp: 2.10 and 2.11 page 6 of 23 • XI_1-7_VSP_Contract: Attachment D, 2.10.vii pages 40-41 of 73 • VSP Contract, Attachment H, item 5, pages 63-64 of 73 • XI_1-7_TD_Contract: Attachment H, 2.10.vii page 25 of 41 • Teledoc contract, Attachment J, item 5, page 36 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, 1.10 page 26 of 41, 1.11 page 26 – 27 of 41 • XI_1-7_NCH_Contract: Attachment A-4-B, item 5, pages 13 – 14 of 41 • XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, #5, page 546 of 554	☒ 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**
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. 42 CFR §438.230(c)(3)(i-iv)	**HSAG Recommended Evidence:** • Delegation agreement/contract template • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • XI_4_DSA_Add_Tmp: 2.10 v-viii, page 6 of 23 • XI_1-7_VSP_Contract: Attachment D, 2.10.v, vi, vii, viii pages 40-41 of 73 • XI_1-7_TD_Contract : Attachment H, 2.10.v, vi, viii, viii page 25 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, 1.10.E, F, G, H, page 26 of 41 • XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, #3, page 546 of 554	☒ 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**
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:** • XI_5_DSA_Add_Tmp: Article 2, page 3-6 of 23 • XI_5_DO_Prgm_Dsc: I.B page 2 of 6, III.B page 4 and Section IV.A, page 5 • XI_1-7_VSP_Contract: Attachment D, 2.4.A page 38 of 73 • XI_1-7_TD_Contract: Attachment H, 2.4.A page 23 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, 1.4 – 1.13 pages 24 – 27 of 41 • XI_5_TD_Adv_Evt_Rpt_Q1_22: page 1 • XI_5_VSP_Clm_Sum_Q1_22: page 1 • XI_5_VSP_CC_Sum_Q1_22: page 1 • XI_5_VSP_CR_Sum_01_22: page 1 • XI_5_VSP_CR_Sum_02_22: page 1 • XI_5_VSP_CR_Sum_03_22: page 1 • XI_5_NDOC_Min_010522_Fnl: page 1 • XI_5_NDOC_Min_111821_Fnl: pages 1-3, 10-11 • XI_5_MHNV_DOC_Com_Mbr_Sched_22: page 1 • XI_5_MHNV_DOC_Min_061322_Dft: pages 1-3	☒ Met ☐ Not Met ☐ NA

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, 3.6, page 14 of 554	
MCO Description of Process:		
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:** • XI_6_DSA_Add_Tmp: 2.4, pages 3-6 of 23 • XI_6_DO_Prgm_Dsc: Section III. page 4 and Section IV.A, page 5 of 6 • XI_1-7_VSP_Contract: Attachment D, 2.4.A pages 38-39 of 73 • XI_1-7_TD_Contract: Attachment H, 2.4.A page 23 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, 1.4 – 1.13 pages 24 – 27 of 41 • XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, #14, page 548 of 554	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, due to the MCO's implementation effective date of the Nevada Medicaid line of business, no annual audits were due during the time period of review. However, the MCO did provide an annual audit schedule for all its delegates.		
Required Actions: None.		

Standard XI—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
7. *If the MCO identifies deficiencies or areas for improvement, the MCO and the subcontractor take corrective action.* 42 CFR §438.230 Contract 7.2.2.2; 7.2.2.8	**HSAG Recommended Evidence:** • Delegation agreement/contract template • Three examples of corrective action plans • Committee meeting minutes • HSAG will use the results from the Delegation File Review **Evidence as Submitted by the MCO:** • XI_7_DSA_Add_Tmp: Article 3, pages 6-7 of 23 • XI_7_DO_Prgm_Dsc: Section III.B-C. pages 4-5 • XI_1-7_VSP_Contract: Attachment D, 3.1 pages 41 of 73 • XI_1-7_TD_Contract: Attachment H, 3.1 pages 25 of 41 • XI_1-7_NCH_Contract: Attachment A-4-D, 1.13, page 27 of 41 • XI_7_NDOC_Min_010522_Fnl: page 1 • XI_7_MHNV_DOC_Min_061322_Dft: pages 1-3 • XI_7_NDOC_Min_111821_Fnl: pages 1-3, 10-11 • XI_7_MHNV_DOC_Com_Mbr_Sched_22: page 1 • XI_7_Renown_CR_PA_CAP: pages 1-10 • XI_1-7_2019 Amended CVS Contract_Nevada Medicaid, #14, page 548 of 554	☒ 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						
Met	=	7	X	1	=	7
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	7	Total Score		=	7
Total Score ÷ Total Applicable					=	100%

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. *The MCO's Chief Medical Director oversees the development and revision of the MCO's clinical care standards and practice guidelines and protocols.* Contract 7.2.1.6.2.3	**HSAG Recommended Evidence:** • Job description • Committee charter • Committee meeting minutes **Evidence as Submitted by the MCO:** P10127 Chief Medical Officer job description HCS Committee Charter 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.		
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:** HCS 365 Clinical Criteria for UM Decision Making Policy HCS-365 Clinical Criteria for UM Decision Making NV State Addendum MHI-QUAL 018 CPG and PHG 2020 Plan Guidelines Quality Program	☒ 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**
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:** MHI-QUAL 018 CPG and PHG 2020 Plan Guidelines Quality Program	☒ 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.		
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:** MHI-QUAL 018 CPG and PHG 2020 Plan Guidelines Quality Program	☒ 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 enhance its MHI-QUAL 018 CPG and PHG 2020 policy and procedure to include additional detail about the specific process describing how the MCO consults with network providers during the adoption of CPGs and also include the process describing how the MCO solicits or receives recommendations for CPGs from network providers. Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XII—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
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:** MHI-QUAL 018 CPG and PHG 2020 Plan Guidelines Quality Program	☒ 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.		
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).* 1. *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:** QTL Testing NV MHPAEA Contract Language and Compliance Checklist HCS 609 Mental Health Parity and Addictions Equity Policy HCS 609 Mental Health Parity and Addictions Equity Procedure	☒ 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:** HCS Program Description Member Newsletter Provider Newsletter Provider Manual	☒ 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: HCS Program Description Plan Guidelines Quality Program MHNV Medicaid Denial_Member_1 MHNV Medicaid Denial_Member_2 MHNV Medicaid Denial_Member_3	
MCO Description of Process:		
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: HCS Program Description Provider Manual	
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**
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:** HCS Program Description	☒ 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 enhance its documentation for evaluating provider adherence to evidence-based practice guidelines and positive and negative variances from standard clinical pathways and specifically the sources of data (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®][A-1] results, audits) used as part of the analyses. Further, HSAG recommends that the MCO define the threshold that will be used to determine when a performance improvement project for network providers would be appropriate, (e.g., aggregated HEDIS results below national Medicaid 25th percentile). Implementation of these recommendations will be evaluated during future compliance reviews.		
Required Actions: None.		

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

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

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems must provide information on areas including, but not limited to: a. Utilization b. Claims payment c. Grievances and appeals d. Disenrollments for other than loss of Medicaid eligibility e. *Enrollment* f. *Eligibility* g. *Provider network data* h. *Encounter data* i. *Electronic Visit Verification (EVV)* 42 CFR §438.242(a) Contract 7.12.2.1; 7.12.2.2; 7.12.4.1	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current Information Systems Capabilities Assessment (ISCA) • Technical manual(s) • HSAG will use the results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCO:** • Electronic Visit Verification – Nevada Medicaid – Job Aid.pdf • Application Information Document_Molina Claims • Claims Payment Policy -MHI.CLMS.04.MCD.NV	☒ 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**
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:** • Molina Overview Systems v4_MA.pdf	☒ 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:** • Claims and Encounters System Document • Claims_and_Encounters_End-to-End_Data_Flow_-_All_States_and_LOBs_-_Job_Aid • Claim_and_Encounter_Submission_Methods_-_All_States_and_LOBs_-_SOP	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information 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.		
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:** • Claim_Encounter_Submission_Methods_-All_States_and_LOBs_-SOP • Claims_and_Encounters_End-to-End_Data_Flow_-_All_States_and_LOBs_-_Job_Aid • MHI.CLMS.04.MCD.NV Claims Payment P&P • Claims and Encounters System 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 XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
5. The MCO must make all collected data *outlined in the Contract, DHCFP's electronic MoveIt reporting repository, or any successor repository, attachments, and guidance* available to the DHCFP and upon request to CMS. 42 CFR § 438.242(b)(4) Contract 7.12.4.1.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements/reports • Encounter data acceptance/rejection reports **Evidence as Submitted by the MCO:** • Claim_Encounter_Submission_Methods_-All_States_and_LOBs_-SOP • Claims and Encounters System Document • Molina Encounters Dashboard (June 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.		
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:** • Member Merge Job Aid • Member with Two Medicaid IDs_Print Screen	☒ 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**
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 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	**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:** • API Requirements	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the MCO provided a narrative which indicated that updated data are available via the API within 24 hours of the data transaction, MCO staff members verbally confirmed that updated data are typically available via the API within four hours.		
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:** • API Requirements	☒ 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 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:**	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• Claim_Encounter_Submission_Methods_-All_States_and_LOBs_-SOP • Claims and Encounters System Document Claims_and_Encounters_End-to-End_Data_Flow_-_All_States_and_LOBs_-_Job_Aid	
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. 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	**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:** • Claim_Encounter_Submission_Methods_-All_States_and_LOBs_-SOP • Claims and Encounters System Document • Molina Encounters Dashboard (June 2022) • MHNV Encounter State Testing Plan_20211210	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
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. As the MCO's process is to submit data to DHCFP weekly or biweekly depending on the type of encounter, 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:** • Claims Payment Policy -MHI.CLMS.04.MCD.NV	☒ 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**
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:** • AID_CCCA • CM-As-Is-Diagram_v1	☒ 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, 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 Claims.* e. *Person centered care treatment plans* f. *Patient assessments* g. *Case management notes* Contract 7.5.6.8.2; 7.5.6.8.4	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • Salesforce_Org5	☒ Met ☐ Not Met ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While screen shots were provided after the site review, HSAG recommends that the MCO prepare to provide a live demonstration of how care managers access the 24-hour nurse line during future compliance reviews.		
Required Actions: None.		
Electronic Visit Verification		
14. *The MCO implements the State's contracted Electronic Visit Verification (EVV) system for the following services:* a. *Personal Care Services, upon the Contract go-live date.* b. *Home Health Services, no later than January 1, 2023.* c. *Any additional services identified by DHCFP.* Contract 7.12.7	**HSAG Recommended Evidence:** • Policies, procedures, and workflows • HSAG will use the results from the information systems demonstration **Evidence as Submitted by the MCO:** • NV_EVV Workflow.pdf • CS0637-CR01_CR02 BRD NV EVV V2.2.docx	☒ Met ☐ Not Met ☐ NA
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	=	14	X	1	=	14
Not Met	=	0	X	0	=	0
Not Applicable	=	0				
Total Applicable	=	14	Total Score		=	14
Total Score ÷ Total Applicable					=	100%

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCO must establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program (*referred to as the Internal Quality Assurance Program [IQAP] in Nevada*) for the services it furnishes to its members. a. *The QAPI program consists of systematic activities, undertaken by the MCO, to monitor and evaluate the care delivered to members according to predetermined, objective standards, and effect improvements as needed.* 42 CFR §438.330(a)(1) Contract 7.9.2.1	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV page 5 and all pages Trilogy 2 – 2022 MHNV QI Work Plan all pages MCO Description of Process: The entirety of the documents, Molina's QI Program Description and Quality Improvement Work Plan, detail our ongoing comprehensive quality assessment and performance improvement program, including our objectives; the Quality Work Plan (an appendix to the Program Description) lists the objectives with identified parties responsible, the timeline and action plan to achieve the objective.	☒ 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:** The QAPI program was submitted to DHCFP on 10/12/21	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
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.		
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:** 2022 QI Program Description_MHNV pages 3 & 4, 7, 14-17 and all pages. Trilogy 2 – 2022 MHNV QI Work Plan all pages	☒ 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.		
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:** 2022 QI Program Description_MHNV pages 3, 5, 6, 8-11, 18, 20-24, 38-39, 55, 67, Trilogy 2 – 2022 MHNV QI Work Plan Sections 5.0, 6.0, 7.0, 9.0, 10.0	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
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:** 2022 QI Program Description MHNV pages 3, 7, 12, 17, 19, 20, 22-24, 32, 46, 68 Trilogy 2 – 2022 MHNV QI Work Plan Section 2.0	☒ 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.		
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:** 2022 QI Program Description_MHNV pages 4, 9, 10, 11, 13, 15, 16, 19, 20, 23, 24	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** While the QI Program Description included how the MCO reviews and monitors over- and underutilization patterns against practice guidelines, treatment planning protocols, and policies, and MCO staff members were able to explain the processes for referring suspected fraud and abuse incidents to the MCO's program integrity unit and the State, HSAG recommends that the MCO enhance its QI Program Description to more clearly indicate the reporting process for suspected fraud and abuse. Implementation of this recommendation will be evaluated during future compliance reviews.		
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:** 2022 QI Program Description_MHNV pages 6-9, 20-22, 27, & 37-38 Trilogy 2 – 2022 MHNV QI Work Plan Sections 2 and 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 XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
8. The QAPI program must include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i), Contract 7.9.3.2.3	**HSAG Recommended Evidence:** • QAPI program description • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Audit tools and results **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV pages 9, 26, 27 Trilogy 2 – 2022 MHNV QI Work Plan 25.0 This isn't offered by the NV Plan at this time; however, these are the references to the program.	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
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.		
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.*	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job descriptions • Training materials **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV pages 13-14	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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	Quality Improvement Org Chart; Sr. Leadership Org Chart; and, NV QIC Charter 2022 – Copy1	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met requirements for this element.		
Required Actions: None.		
10. *The MCO must have QI teams composed of MCO staff fully dedicated to the managed care program that represent the following areas of expertise:* a. *Continuous quality improvement.* b. *Analytics.* c. *Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts.* d. *Health equity.* e. *The MCO's policies and processes related to the improvement topic.* f. *Member and provider perspectives (may be staff or liaisons with the MCO's member and provider services departments).* Contract 7.9.4.13.2; 7.9.4.13.2.1-7.9.4.13.2.6	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV pages 13-14 Quality Improvement Org Chart; Sr. Leadership Org Chart; and, NV QIC Charter 2022 – Copy1	☒ 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**
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:** 2022 QI Program Description_MHNV pages 33-41, 52 NV QIC Charter 2022 – Copy1	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the Member Services Subcommittee and Member Advisory Board serve as a joint committee. Additionally, the Provider Advisory Board and Provider Services Subcommittee appear to serve as one committee.		
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:** 2022 QI Program Description_MHNV pages 32-40, 50, 71 03 03 22 Board Meeting Minutes; 06 30 22 Board Meeting Minutes; 03 10 22 MHNV QIC Meeting Minutes; and, 06 02 22 MHNV QIC Meeting Minutes	☒ 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. *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:** 2022 QI Program Description_MHNV pages 25, 36, 41	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	Invitation to Join Molina's QIC; 03 10 22 MHNV QIC Meeting Minutes; 06 02 22 MHNV QIC Meeting Minutes; and, NV QIC Charter 2022 – Copy1	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
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:** Nevada Provider Advisory Board Charter Final 2022 QI Program Description_MHNV	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO's Provider Advisory Board Charter identified the required membership for the Provider Advisory Board; however, there was not a quorum for the first quarterly meeting, and the second quarterly meeting was scheduled after the site review.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG strongly recommends that the MCO have strategies in place to ensure the MCO has and continues to have broad representation of network providers who actively participate in the 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:** Nevada Provider Advisory Board Charter Final 2022 QI Program Description_MHNV	☒ 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.		
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:**	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	List of Members on the Member Advisory Committee; Member Advisory Committee Charter 2022; 02 16 22 Member Advisory Committee Meeting Minutes; and, 05 15 22 Member Advisory Committee Meeting Minutes.	
MCO Description of Process:		
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:** Member Advisory Committee Charter 2022; 02 16 22 Member Advisory Committee Meeting Minutes; and, 05 15 22 Member Advisory Committee Meeting Minutes.	☐ Met ☒ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: The MCO did not submit the Member Advisory Board minutes to DHCFP within 30 calendar days of the meeting as required by contract. Of note, the MCO did provide documentation that the minutes for three prior Member Advisory Board meetings (e.g., February, May, and August) were submitted to DHCFP on September 13, 2022, which was beyond the required 30-calendar-day submission time frame for the February and May meetings.		
Required Actions: The MCO must ensure that the Member Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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:** Member Advisory Committee Charter 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.		
Performance Measurement		
19. The QAPI program must include the collection and submission of performance measurement data. The MCO must annually: a. Measure and report to DHCFP on its performance, using the standard measures required by DHCFP; b. Submit to DHCFP data, specified by DHCFP, which enables DHCFP to calculate the MCO's performance using the standard measures identified by DHCFP; or c. Perform a combination of the activities described in subelements (a) and (b).	**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:** 2022 QI Program Description_MHNV pages 25 28 – 29 Molina has been in operation less than one year.	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(b)(2) 42 CFR §438.330(c) Contract 7.9.2.9-7.9.2.9.10		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO has only been operational in the Nevada Medicaid managed care program since January 2022 and therefore was not due to report performance measure data during the time period under review.		
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.* 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.*	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • Policies and procedures • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** Trilogy 2 – 2022 MHNV QI Work Plan Section 26 03 10 22 MHNV QIC Meeting Minutes; 06 02 22 MHNV QIC Meeting Minutes; and, 06 02 22 QIC Quality Updates.	☐ Met ☐ Not Met ☒ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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		
MCO Description of Process:		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
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:** Trilogy 2 – 2022 MHNV QI Work Plan Section 26 03 10 22 MHNV QIC Meeting Minutes; 06 02 22 MHNV QIC Meeting Minutes; and, 06 02 22 QIC Quality Updates.	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, while the QI Program Description 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.* 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	**HSAG Recommended Evidence:** • QAPI program description • QAPI work plan • PIP documentation for all active PIPs **Evidence as Submitted by the MCO:** Trilogy 2 – 2022 MHNV QI Work Plan Section 26 03 10 22 MHNV QIC Meeting Minutes; 06 02 22 MHNV QIC Meeting Minutes; and, 06 02 22 QIC Quality Updates.	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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) Contract 7.9.2.8; 7.9.5.3	**HSAG Recommended Evidence:** • Evidence of annual submission, including the documentation that was submitted, of all PIPs to DHCFP **Evidence as Submitted by the MCO:** Trilogy 2 – 2022 MHNV QI Work Plan Section 26 MHNV Q22022 BOD Final Slides (002) 03 10 22 MHNV QIC Meeting Minutes; 06 02 22 MHNV QIC Meeting Minutes; and, 06 02 22 QIC Quality Updates.	☐ Met ☐ Not Met ☒ NA
MCO Description of Process:		
HSAG Findings: As DHCFP did not announce the required PIP topics to the MCOs until May 2022, HSAG has determined that the requirements of this element are not applicable. The MCO's compliance with these PIP requirements will be evaluated during future compliance reviews.		
Required Actions: None.		
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:** 702 Critical Incident Report Instruction; Critical Incident Report Template; HCS-197 Critical Incidents Policy;	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	HCS-197.01 Critical Incidents Procedure; and NV Critical Incident Report Template – Copy (1)	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
25. *The MCO must designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of Section 7.9.14 of the Contract.* a. *This position may be assigned as a responsibility to a lead within the quality department and may or may not be a full time equivalent (FTE).* Contract 7.9.14.1	**HSAG Recommended Evidence:** • QAPI program description • Quality staffing structure/organizational chart • Job description **Evidence as Submitted by the MCO:** 702 Critical Incident Report Instruction; Critical Incident Report Template; HCS-197 Critical Incidents Policy; HCS-197.01 Critical Incidents Procedure; and NV Critical Incident Report Template – Copy (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.		
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.	**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)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.330(b)(5)(ii) Contract 7.9.14	**Evidence as Submitted by the MCO:** 702 Critical Incident Report Instruction; Critical Incident Report Template; HCS-197 Critical Incidents Policy; HCS-197.01 Critical Incidents Procedure; and NV Critical Incident Report Template – Copy (1)	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
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.*	**HSAG Recommended Evidence:** • QAPI program description • Critical incident policies and procedures • Three examples of completed critical incident reports **Evidence as Submitted by the MCO:** 702 Critical Incident Report Instruction; Critical Incident Report Template; HCS-197 Critical Incidents Policy; HCS-197.01 Critical Incidents Procedure; and NV Critical Incident Report Template – Copy (1)	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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.* 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.*	**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:** 702 Critical Incident Report Instruction; Critical Incident Report Template;	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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.* Contract 7.9.14.3; 7.9.14.3.1-7.9.14.3.10	HCS-197 Critical Incidents Policy; HCS-197.01 Critical Incidents Procedure; and NV Critical Incident Report Template – Copy (1)	
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.*	**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:** 702 Critical Incident Report Instruction; Critical Incident Report Template;	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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	HCS-197 Critical Incidents Policy; HCS-197.01 Critical Incidents Procedure; and NV Critical Incident Report Template – Copy (1)	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
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** Quality Improvement Program Screenshot Member Newsletter	☒ 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**
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:** Provider Newsletter Provider Manual	☒ 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.		
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;*	**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:** 2022 QI Program Description_MHNV pages 52-53	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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		
MCO Description of Process:		
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.		
Required Actions: None.		
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.*	**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:** 2022 QI Program Description_MHNV pages 52-53	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
Contract 7.9.4.8.1; 7.9.4.8.1.1-7.9.4.8.1.6		
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. **Recommendations:** HSAG recommends that the MCO develop a POC template that includes all of the required components under this element and distribute the template to all departments who may require a POC (e.g., Quality, Provider Services, Program Integrity). Implementation of this recommendation will be evaluated during future compliance reviews.		
Required Actions: None.		
34. *As actions are taken to improve care, the MCO must monitor and evaluate the POC to assure required changes have been made.* a. *In addition, changes in practice patterns must be monitored.* b. *The MCO must assure timely follow-up on identified issues to ensure actions for improvement have been effective.* Contract 7.9.4.8.2	**HSAG Recommended Evidence:** • QAPI program description • Policies and procedures • Evidence of monitoring of all active provider POCs during the time period under review **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV pages 52-53	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
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.		
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:**	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	2022 QI Program Description_MHNV page 33 Trilogy 2 – 2022 MHNV QI Work Plan Section 1.0 MHNV Q22022 BOD Final Slides (002) 03 03 22 Board Meeting Minutes; 06 30 22 Board Meeting Minutes; 03 10 22 MHNV QIC Meeting Minutes; and, 06 02 22 MHNV QIC Meeting Minutes	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element.		
Required Actions: None.		
36. *The governing body has formally designated an entity or entities within the MCO to provide oversight of the QAPI program and is accountable to the governing body, or has formally decided to provide such oversight as a committee of the whole.* Contract 7.9.4.10.2	**HSAG Recommended Evidence:** • QAPI program description **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV page 33 MHNV Q22022 BOD Final Slides (002) 03 03 22 Board Meeting Minutes; 06 30 22 Board Meeting Minutes; 03 10 22 MHNV QIC Meeting Minutes; and, 06 02 22 MHNV QIC Meeting Minutes	☒ 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**
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:** 2022 QI Program Description_MHNV page 33 MHNV Q22022 BOD Final Slides (002) 03 03 22 Board Meeting Minutes; 06 30 22 Board Meeting Minutes; 03 10 22 MHNV QIC Meeting Minutes; and, 06 02 22 MHNV QIC Meeting Minutes	☒ 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.		
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:** 2022 QI Program Description_MHNV pages 33, 37 MHNV Q22022 BOD Final Slides (002) 03 03 22 Board Meeting Minutes;	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	06 30 22 Board Meeting Minutes; 03 10 22 MHNV QIC Meeting Minutes; and, 06 02 22 MHNV QIC Meeting Minutes	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO has only been operational in the Nevada Medicaid managed care program since January 2022 and therefore, was not due to submit the annual quality program evaluation to DHCFP during the time period under review.		
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:** MHNV Q22022 BOD Final Slides (002) 03 03 22 Board Meeting Minutes; 06 30 22 Board Meeting Minutes; 03 10 22 MHNV QIC Meeting Minutes; and, 06 02 22 MHNV QIC Meeting Minutes	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, MCO staff members indicated that during the time period under review there were no program modifications requested by the board due to findings or issues of concern. **Recommendations:** HSAG recommends that the MCO enhance the board meeting minutes to include additional detail on the discussion topics and action items. 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**
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:** 2022 QI Program Description_MHNV pages 49-50 06 02 22 QIC Quality Updates 2022 QI Program Description_MHNV all pages Trilogy 2 – 2022 MHNV QI Work Plan all pages Molina has been in operation less than one year.	☒ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO has only been operational in the Nevada Medicaid managed care program since January 2022 and therefore, was not due to evaluate the impact and effectiveness of its QAPI program during the time period under review.		
Required Actions: None.		

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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 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*	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV pages 49-50 06 02 22 QIC Quality Updates 2022 QI Program Description_MHNV all pages Trilogy 2 – 2022 MHNV QI Work Plan all pages Molina has been in operation less than one year	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
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:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO has only been operational in the Nevada Medicaid managed care program since January 2022 and therefore was not due to evaluate the impact and effectiveness of its QAPI program during the time period under review.		
Required Actions: None.		
42. *The MCO's evaluation also includes:* a. *How the MCO will incorporate the results in its quality improvement strategy.* b. *How the MCO plans to update its quality improvement strategy based on the findings of the self-evaluation.* Contract 7.9.4.9.5.1-7.9.4.9.5.2	**HSAG Recommended Evidence:** • QAPI program evaluation **Evidence as Submitted by the MCO:** 2022 QI Program Description_MHNV pages 49-50 06 02 22 QIC Quality Updates 2022 QI Program Description_MHNV all pages	☒ Met ☐ Not Met ☐ NA

Standard XIV—Quality Assessment and Performance Improvement Program		
Requirement	**Supporting Documentation**	**Score**
	Trilogy 2 – 2022 MHNV QI Work Plan all pages Molina has been in operation less than one year	
MCO Description of Process:		
HSAG Findings: HSAG has determined that the MCO met the requirements for this element. Of note, the MCO has only been operational in the Nevada Medicaid managed care program since January 2022 and therefore was not due to evaluate the impact and effectiveness of its QAPI program during the time period under review.		
Required Actions: None.		

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

Appendix B. Compliance Review Corrective Action Plan

SFY 2021–22 Compliance With Standards Review Tool CAP Template

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
General Rules			
42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) Contract 7.6.2.3; 7.9.6	2. The MCO must follow a documented process for credentialing and recredentialing of network providers that meets DHCFP's requirements for acute, primary, behavioral, substance use disorders, and long-term services and supports (LTSS) providers. a. *The MCO complies with Nevada Administrative Code (NAC) 679B0405, which requires the use of Form NDOI-901 for use in credentialing providers.* b. *In the event State regulations or provider licensure laws conflict with the National Committee for Quality Assurance (NCQA) standards, State regulations and provider licensure laws control for purposes of the credentialing process.*	**Evidence as Submitted by the MCO:** • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • CR02 Assessment and Reassessment of Organizational Providers Policy • CR02 Assessment and Reassessment of Organizational Providers Procedure • NV 2021 CR01 Nevada State Addendum • NV Credentialing Application	☐ Met ☒ Not Met ☐ NA

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

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO[B-1]**	**Score**
	MCO Description of Process: Molina has a uniform credentialing and recredentialing procedure for the selection and retention of all providers to include acute, primary, behavioral, substance use disorders and LTSS practitioners. Molina follows this documented procedure for credentialing and recredentialing network practitioners. The NV 2021 CR01 Addendum details the requirement to use ND01-901 for applicable provider types and state regulations/licensure laws.		
	HSAG Findings: The case file review confirmed that the state-required Form NDOI [Nevada Division of Insurance]-901 was not consistently being used. These findings primarily related to providers being credentialed by one of the MCO's delegates, and MCO staff members confirmed that the delegate was using its own form. For one of the files pertaining to the MCO's cases, the provider was located in Arizona; therefore, Form NDOI-901 was inadvertently not pulled for this provider.		
	Required Actions: The MCO and its delegates must use Form NDOI-901 when credentialing providers in accordance with the MCO's contract with DHCFP and the NAC.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
File Reviews			
42 CFR §438.214 Contract 7.6.2.3.4	10. The MCO complies with individual practitioner recredentialing requirements as specified in the Practitioner Credentialing and Recredentialing File Review Tool.	**Evidence as Submitted by the MCO:** • CR01 Credentialing and recredentialing Practitioners Policy • CR01 Credentialing and recredentialing Practitioners Procedure • NV Credentialing Application • Primary Source Verification Workflow • Decision Notice Templates (approval, deferral, denial, termination)	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: Molina formally recredentials its practitioners every 36 months according to procedure details and criteria outlined in CR01. As part of this recredentialing process Molina reviews performance indicators which include number of Potential Quality of Care cases, the number of member grievances against the practitioner since the last credentialing cycle, and the date of the latest claim processed. Templates for credentialing application and decision notices included. Primary Source Verification workflow is an internal document used by our team with currently approved primary sources for verifications needed to complete recredentialing.		
	HSAG Findings: The case file review identified one of the files in which the provider was located in Arizona; therefore, Form NDOI-901 was inadvertently not pulled for this provider. Because the Council for Affordable Quality Healthcare (CAQH) application was used for this provider instead of Form NDOI-901, two of the disclosure questions did not fully align with the Nevada-specific questions (i.e., reasons for inability to perform the essential functions of the position, "*including any physical or behavioral health problems that may affect current ability to provide health care,"* and lack of present illegal drug use, "*including any history of chemical dependency or substance abuse."* Additionally, the MCO's case files included a "*Recredentialing Performance Review*" form which included the *"# of Potential Quality of Care Cases,*" *"# of Member Complaints,*" *"# of Dirty Office Complaints,*" and "*Date of last claims paid.*" However, this does not fully align with DHCFP's contract provision that requires the recredentialing process to include a review of data from all of the following: member grievances and appeals, quality reviews, utilization management, and member satisfaction surveys. After the site review, the		

Standard VIII—Provider Selection			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	MCO explained that the last claim paid date confirms if the provider is actively seeing the MCO's members, and that no recent claims activity may indicate that the provider is not needed in the network. While this may be an important aspect for the MCO to consider, it is not an indicator that evaluates the performance of providers using utilization management data (e.g., over- and underutilization of services). Further, the MCO is required to consider the results of member satisfaction surveys. If these results are not linked to a specific provider, the MCO should have this documented to confirm it considered this activity, but no provider-specific results were available. Lastly, performance reviews were included in the case files pertaining to the MCO's delegates, but the performance reviews did not fully align with the data elements required to be reviewed during the recredentialing process according to the MCO's contract with DHCFP. The MCO explained that the documents demonstrate how a hospital system reviews practitioner information at recredentialing. If any areas are identified for the practitioner, the MCO would provide these data to the delegate to include in the delegate's review. If there was no data to provide, it would not be included by the delegate. However, the MCO did not clearly demonstrate this process during the site review, and it should still be documented in the recredentialing file. Further, some of the performance review information in the delegate's case files included data collected after the provider was recredentialed, confirming that this information could not have been considered at the time of recredentialing. A case/procedure summary was also included in the case files; however, the date span for these data ended five to six months prior to the provider's recredentialing date. The intent of the requirement is to review performance data that are available during the entire three-year period between recredentialing cycles. Of note, while the MCO was new to the Nevada Medicaid managed care program, the MCO reported those practitioners who were being recredentialed for another program or delegate as "recredentialed." As such, the MCO's recredentialing processes were evaluated as part of this compliance review.		
	Required Actions: The MCO must comply with all individual practitioner recredentialing requirements as specified in 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 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:** • X.7 Member Grievance Process (Medicaid) – pg. 2-4 • X.7 Letter – Mbr Grievance Resolution Letter – approved by DHCFP 1-4-22 • X.7 Letter – Mbr PQOC Grievance Resolution Letter – approved by DHCFP 1-4-22 • X.7 Letter – Mbr Griev Unable to Reach – approved by DHCFP 1-4-22 • X.7 NV Medicaid Member Handbook pg 62	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Grievance Process explains the resolution timeframe and how it should be delivered to the member.		
	HSAG Findings: Although all grievances were reviewed and resolved, and written notification was sent to members within 90 days for all case files reviewed, the grievance resolution notices did not include taglines in conspicuously visible font as required by 42 CFR §438.10. **Recommendations:** Grievance resolution letters reviewed as part of the case file review included acronyms that were not spelled out and/or contained typographical or grammatical errors; therefore, HSAG recommends that the MCO enhance its existing process to quality check letters prior to mailing to members. Additionally, although the grievance resolution letters were dated, HSAG recommends that the MCO include the date of resolution within the body of the letter. Further, the Medicaid Grievance Process (Medicaid) policy included conflicting time frames regarding when grievances should be resolved. Although the MCO confirmed that the policy is to resolve grievances within 90 days, HSAG recommends the MCO update its policy and member materials to ensure there are no conflicting time frames (i.e., 30 days versus 90 days). Finally, although the MCO made		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	one attempt to outreach to members to notify them of the grievance resolution as indicated through the case file review, the MCO indicated that it expects staff members to make at least two attempts to notify the member of the grievance resolution orally. As such, HSAG recommends that the MCO ensure its staff members comply with these expectations and update its policy to clearly indicate that two attempts will be made to notify the member orally of the grievance resolution. Implementation of these recommendations will be evaluated during future compliance reviews.		
	Required Actions: The MCO must ensure the written notice of resolution meets the standards described at 42 CFR §438.10 and includes taglines in the prevalent non-English languages spoken in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free teletypewriter (TTY)/telecommunications device for the deaf (TTD) telephone number of the MCO's member/customer service unit.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Handling of Appeals			
42 CFR §438.406(b)(1) 42 CFR §438.410(c) 42 CFR §438.228 Contract 7.8.10.5.3	15. If the MCO denies a request for expedited resolution of an appeal, it must: a. Transfer the appeal to the time frame for standard resolution *of no longer than thirty (30) calendar days from the day the MCO receives the appeal.* b. Follow the requirements in 42 CFR §438.408(c)(2), including: i. Make reasonable efforts to give the member prompt oral notice of the delay. ii. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision.	**Evidence as Submitted by the MCO:** • X.15 Member Appeal Process (Medicaid) – pgs. 3-7 • X.15 NV Medicaid Member Handbook – pg 64 • X.15 Letter – Mbr Exp Appeal Denial Letter – approved by DHCFP 1-4-22	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Appeal Process explains how a denied request for an Expedited Appeal is handled through the Standard Appeals Process.		
	HSAG Findings: The MCO's Member Appeal Process (Medicaid) policy appropriately indicated that if an expedited appeal request does not meet expedited criteria, the coordinator will provide immediate oral notice to the member and follow up within two calendar days with a written notice of the denial to expedite the appeal. The Expedited Appeal Denied template letter also included appropriate language to meet the intent of the requirements under this element. However, as indicated through the case file review, MCO staff members did not follow the MCO's process and provide members with oral and written notice of the decision to process the appeal under the standard time frame. After the site review, the MCO confirmed that the appeals included as part of the file review were mishandled by the assigned coordinator.		

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

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Handling of Appeals			
42 CFR §438.406(b)(4) 42 CFR §438.228 Contract 7.8.10.9.2; 7.8.10.10.6	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.	**Evidence as Submitted by the MCO:** • X.19 Member Appeal Process (Medicaid) – pg. 6 • X.19 NV Medicaid Member Handbook – pg 63 & 64 • X.19 NV Mbr Additional Information Needed – approved by DHCFP 5-13-22 • X.19 NV NABD Letter – Draft EN_V4	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Appeal Process explains that Members have an opportunity to present additional information pertaining to their case.		
	HSAG Findings: The Member Appeal Process (Medicaid) policy stipulated the requirements of this element. Additionally, a copy of the member handbook was provided as evidence to demonstrate that members were provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Although the member handbook indicated, "you have the opportunity to present Molina with evidence of the facts or law about your case, in person or in writing," the member handbook is not a substitute to providing this information at the time of an adverse benefit determination (ABD) and/or during the appeal process. Additionally, the member handbook did not inform members of the limited time available for this opportunity sufficiently in advance of the resolution time frame for expedited appeals. Further, although the MCO's ABD template was provided as evidence, it also does not adequately inform members of this opportunity. **Recommendations:** To ensure members are notified in a timely manner of their right to present evidence and testimony and make legal and factual arguments for their appeal, HSAG recommends the MCO consider providing this information orally to members when contacting them about their appeal and documenting the discussion within the appeal call notes, adding language to the ABD notice, and/or adding language to the appeal acknowledgement letters. For expedited appeals, HSAG also recommends the MCO should consider discussing this opportunity with the member at the time the appeal is being filed and documenting the discussion in the appeal call notes. Implementation of these recommendations will be evaluated during future compliance reviews.		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	Required Actions: The MCO must provide members a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. 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.		
Corrective Action Plan (Include required action, responsible individual, and completion date.)			
DHCFP Feedback (To be completed by DHCFP/HSAG.)			☐ Accepted ☐ Accepted With Recommendations ☐ Not Accepted

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
Resolution and Notification of Appeals			
42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §438.10 42 CFR §438.228	26. For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's ABD related to the appeal.	**Evidence as Submitted by the MCO:** • X.26 Member Appeal Process (Medicaid) – pg. 3, 7, 9-10 • X.26 Mbr Standard Non-Clinical Appeal Resolution Letter (Overturn) – approved by DHCFP 1-4-22 • X.26 Mbr Standard Non-Clinical Appeal Resolution Letter (Upheld) – approved by DHCFP 1-4-22 • X.26 Mbr Standard Expedited Appeal Resolution Letter (Overturn) – approved by DHCFP 1-4-22 • X.26 Mbr Standard Expedited Appeal Resolution Letter (Upheld) – approved by DHCFP 1-4-22 • X.26 NV Medicaid Member Handbook – pg 3-6, 22,43,60	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Appeal Process describes the resolution that should be given to the member and the next steps if the decision is unfavorable for the member.		
	HSAG Findings: One appeal resolution letter reviewed as part of the case file review indicated that the appeal was partially approved; however, the notice did not include SFH rights or information about continuing benefits. After the site review, MCO staff members explained that there was no denial, and that if a partial denial of services did occur, the member would receive two notices, including a notice of denial that would contain SFH rights and information about continuation of benefits. However, because the appeal resolution notice reviewed as part of the case file review indicated that "we have PARTIALLY APPROVED your treatment," this confirms that services were also partially denied. In review of the appeal resolution notice,		

Standard X—Grievance and Appeal Systems			
Reference	**Requirement**	**Information Submitted as Evidence by the MCO**	**Score**
	services were requested for a period of eight months; however, the MCO's appeal resolution letter indicated that "we could not approve all the dates asked." Please also refer to findings under Element 7 regarding noncompliance with tagline requirements under 42 CFR §438.10. **Recommendations:** Although the MCO indicated that the date of the letter is the appeal resolution date, HSAG strongly recommends that the MCO consider adding the appeal resolution date in the body of the resolution notice. Further, most appeal resolution letters reviewed as part of the case file review contained minor typographical and/or grammatical issues, such as incomplete sentences or shortened words (e.g., meds). Therefore, HSAG recommends that MCO staff members develop a quality assurance process, or enhance the existing process, for reviewing resolution letters prior to being sent to members. Implementation of these recommendations will be evaluated during future compliance reviews.		
	Required Actions: For all appeals, the MCO must provide written notice of the resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. The written notice of the appeal resolution must also include the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member, the notice must also include the right to request a SFH, and how to do so; the right to request and receive benefits while the hearing is pending, and how to make the request; and 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.		
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:** • X.27 Member Appeal Process (Medicaid) – pg. 3 & 7	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process: The Appeal Process explains that resolutions for Standard and Expedited Appeals must be provided to the Member in writing and an attempt should be made to provide the resolution orally too		
	HSAG Findings: One appeal reviewed as part of the case file review did not demonstrate that attempts were made to provide the member with oral notification of the resolution. Additionally, although the MCO indicated that the expectation is for staff members to make at least two outreach attempts, only one of the appeals reviewed as part of the case file review supported that staff members were making at least two outreach attempts to notify members orally of the appeal resolution.		
	Required Actions: 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.		
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**
Quality Assurance Committee			
Contract 7.9.4.15.5	17. *The Member Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.*	**Evidence as Submitted by the MCO:** Member Advisory Committee Charter 2022; 02 16 22 Member Advisory Committee Meeting Minutes; and, 05 15 22 Member Advisory Committee Meeting Minutes.	☐ Met ☒ Not Met ☐ NA
	MCO Description of Process:		
	HSAG Findings: The MCO did not submit the Member Advisory Board minutes to DHCFP within 30 calendar days of the meeting as required by contract. Of note, the MCO did provide documentation that the minutes for three prior Member Advisory Board meetings (e.g., February, May, and August) were submitted to DHCFP on September 13, 2022, which was beyond the required 30-calendar-day submission time frame for the February and May meetings.		
	Required Actions: The MCO must ensure that the Member Advisory Board meets quarterly with minutes submitted to DHCFP within thirty (30) calendar days of the meeting.		
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